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-Application
Saint Thomas Midtown Hospital

CN1401-001

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CMH01-001

Saint Thomas
MIDTOWN HOSPITAL

CENTER OF EXCELLENCE
FOR
TOTAL JOINT REPLACEMENT SERVICES
AT
SAINT THOMAS MIDTOWN HOSPITAL

CERTIFICATE OF NEED APPLICATION
JANUARY 2014

Saint Thomas Health

January 15, 2014

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application-Saint Thomas Midtown Hospital

Dear Ms. Hill:

As notified in the letter of intent dated January 10, 2014, Saint Thomas Midtown Hospital is filing for a Certificate of Need for renovations to accomplish the realignment and consolidation of total joint replacement services at Saint Thomas Midtown Hospital. The original and two copies of the application are included in this packet.

This application replaces the previous one submitted by Midtown Hospital (CN1307-028). As a result, we request that the previous application that had been deferred for review be withdrawn.

Please let me know if you have any questions or need any further information.

Respectfully,

Barbara Houchin
Executive Director, Planning

cc: Bernie Sherry
Warren Gooch

SECTION A:

APPLICANT PROFILE

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate *"N/A."* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.***

For Section A, Item 1, *Facility Name* ***must be*** *applicant facility's name and address* ***must be*** *the site of the proposed project.*

For Section A, Item 3, *Attach a copy of the partnership agreement, or corporate charter* ***and*** *certificate of corporate existence, if applicable, from the Tennessee Secretary of State.*

For Section A, Item 4, *Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in* Tennessee Code Annotated, §68-11-1602 *in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.*

For Section A, Item 5, *For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.*

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

For Section A, Item 6, *For applicants or applicant's parent company/owner that currently own the building/land for the project location; attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application.

1. ***Name of Facility, Agency, or Institution***

Saint Thomas Midtown Hospital		
Name		
2000 Church Street	Davidson	
Street or Route	County	
Nashville	Tennessee	37236
City	State	Zip Code

2. ***Contact Person Available for Responses to Questions***

Barbara Houchin		Executive Director, Planning	
Name		Title	
Saint Thomas Health		bhouchin@sth.org	
Company Name		Email address	
102 Woodmont Boulevard, Suite 800	Nashville	Tennessee	37205
Street or Route	City	State	Zip Code
Executive Director, Planning		615-284-6849	615-284-7403
Association with Owner		Phone Number	Fax Number

3. ***Owner of the Facility, Agency or Institution***

Saint Thomas Midtown Hospital		615-284-6869
Name		Phone Number
102 Woodmont Blvd, Suite 800		Davidson
Street or Route		County
Nashville	Tennessee	37205
City	State	Zip Code

4. ***Type of Ownership of Control (Check One)***

A.	Sole Proprietorship	F.	Governmental (State of TN or Political Subdivision)
B.	Partnership	G.	Joint Venture
C.	Limited Partnership	H.	Limited Liability Company
D.	Corporation (For Profit)	I.	Other (Specify)
E.	Corporation (Not-for-Profit) X		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

5. ***Name of Management/Operating Entity (If Applicable)***

Name

Street or Route

County

City

ST

Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	X	D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify) _____	
C.	Lease of _____ Years				

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify) Acute Care	X	I.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center	
C.	ASTC, Single Specialty		K.	Recuperation Center	
D.	Home Health Agency		L.	Rehabilitation Facility	
E.	Hospice		M.	Residential Hospice	
F.	Mental Health Hospital		N.	Non-Residential Methadone Facility	
G.	Mental Health Residential Treatment Facility		O.	Birthing Center	
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		P.	Other Outpatient Facility (Specify)	
			Q.	Other (Specify) _____	

8. **Purpose of Review *(Check as appropriate--more than one response may apply)***

A.	New Institution		G.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
B.	Replacement/Existing Facility				
C.	Modification/Existing Facility	X			
D.	Initiation of Significant Health Care Service as defined in TCA § 68-11-1607(4) (Specify)_____				
E.	Discontinuance of OB Services		H.	Change of Location	
F	Acquisition of Equipment		I.	Other (Specify)_____	

9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

		Current Beds		Staffed Beds	Beds Proposed	TOTAL Beds at Completion
		Licensed	*CON			
A.	Medical	355		147		355
B.	Surgical (General Med/Surg)	102		96		102
C.	Long-Term Care Hospital					
D.	Obstetrical	104		97		104
E.	ICU/CCU	46		37		46
F.	Neonatal	52		52		52
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation	24		24		24
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	683		453		683

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** 044-0133

Certification Type Acute Care Hospital

11. **Medicaid Provider Number** 044-0133

Certification Type Acute Care Hospital

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?** N/A

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants? Yes If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or *plans to contract.***

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

RESPONSE: Midtown Hospital participates in the major TennCare MCOs serving the majority of the patients in the area: UnitedHealthcare Community Plan (f/k/a Americhoice) and Amerigroup. Negotiations are underway with TennCare Select and BlueCare. In total, Midtown Hospital participates in approximately 44 managed care organizations/behavioral health organizations. Please see **Attachment A,13 (Tab 6)** for a list of managed care contracts in which Midtown Hospital participates.

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

RESPONSE: Please see the following executive summary.

ORTHOPEDIC OPERATING ROOMS (10), PATIENT CARE AREAS AND SUPPORT SPACE TOTAL JOINT REPLACEMENT SERVICES REALIGNMENT, CONSOLIDATION, RELOCATION AND EXPANSION (RESIZING)

APPLICANT OVERVIEW: For more than 90 years, Saint Thomas Midtown Hospital ("Midtown Hospital") has been devoted to physical, emotional and spiritual healing. Midtown Hospital is the largest not-for-profit community hospital in Middle Tennessee, licensed for 683 acute and rehab care beds. Midtown Hospital's heritage of healing is one of continuous growth, community service and superior care. Recent achievements in clinical care include:

- Nation's 100 Top Hospitals by Thomson Reuters and 100 Top Hospitals Everest Award
- Three-Year Approval with Commendation from the Commission on Cancer of the American College of Surgeons
- First health care facility in Tennessee to earn the Gold Seal of Approval for total hip and knee replacement from The Joint Commission
- Blue Distinction Center for Knee and Hip Replacement by Blue Cross Blue Shield
- Top 100 hospital for hip and knee complications (minimal) following surgery by the Centers for Medicare & Medicaid Services
- Top 100 hospital for hip and knee readmissions (minimal) following surgery by the Centers for Medicare & Medicaid Services (affiliate, Saint Thomas West Hospital)
- Recognized for quality in hip and knee surgery by the Centers for Medicare & Medicaid Services along with Saint Thomas West Hospital – the only two hospitals in Nashville to receive this recognition

PROPOSED SERVICES AND EQUIPMENT: Midtown Hospital is not proposing any new services or CON reviewable equipment. As described more fully in the need section below, this project is to build a center of excellence for total joint replacement services on the Midtown Hospital campus that includes developing a new operating suite for joint replacement surgeries. When the project is completed,

Midtown Hospital will have ten dedicated operating rooms appropriately sized and equipped for the needs of joint replacement procedures. This will allow for coordination and consolidation of joint replacement programs across Saint Thomas Health's two Nashville campuses – Midtown and West – resulting in greater efficiency and operation. This ten operating room project also remains operating room neutral in the market while capitalizing on the strengths of two award-winning total joint replacement programs.

To stage the project, it will be necessary to:

- Renovate two existing nursing floors of the hospital, both located on the eighth floor but in interconnected towers, to create 62 private inpatient beds dedicated to total joint replacement services. Midtown Hospital will redistribute patients currently cared for on these nursing floors to the fifth and sixth floors of the hospital and, therefore, the hospital's licensed bed capacity will not change.
- Create a PACU with 12 private bays and a Prep/Recovery area with 20 private bays on the eighth floor, dedicated to total joint replacement surgery services.
- Resize and relocate two existing ORs on the eighth floor of Midtown Hospital (increasing the size from 333 square feet each to 585 square feet each).
- Create a new central sterile processing center in the basement and connected to the eighth floor via a dedicated elevator bank.

OWNERSHIP STRUCTURE: Midtown Hospital is a member of Nashville-based Saint Thomas Health, which is part of Ascension Health. Ascension Health is a Catholic organization that is the largest not-for-profit health system in the United States. Other members of Saint Thomas Health include Saint Thomas West Hospital in Nashville, Saint Thomas Rutherford Hospital in Murfreesboro and Saint Thomas Hickman Hospital in Centerville. The proposed project will not result in a change in ownership structure.

SERVICE AREA: Based on historical patient origin data, Midtown Hospital's service area for this project is comprised of 12 counties in Middle Tennessee. As reported in the hospital's FY2012 patient origin data, this 12-county area represents 89.5% of Midtown Hospital's inpatient discharges – Cheatham, Davidson, Dickson, Hickman, Humphreys, Maury, Montgomery, Robertson, Rutherford, Sumner, Williamson and Wilson.

NEED: Proposed renovations at Midtown Hospital to build a total joint replacement center of excellence and consolidated program for Saint Thomas Health's two Nashville hospitals will be attractive to both patients and physicians. This project will improve operational efficiency across the health system, provide ORs that are large enough to accommodate imaging equipment and larger operating tables and enhance the overall quality of total joint replacement surgery services. Achieving these objectives was instrumental in the decision to proceed with this project at Midtown Hospital.

- Improve patient flow and operational efficiency: The total joint replacement operating rooms at Saint Thomas Health are not centrally located, which creates poor patient flow and operational inefficiencies across the hospital campuses. Because the operating rooms are not in a single location, it is difficult to maximize physician and staff productivity as well as provide efficient and seamless patient flow. By consolidating the total joint replacement operating rooms on the eighth floor of the hospital with a dedicated PACU and Prep/Recovery, Midtown Hospital will be able to enhance operational efficiency and staff productivity. In addition, inpatient surgical patients will be cared for on two adjacent nursing units, which should further enhance patient flow and care coordination.

- Provide operating rooms large enough to accommodate needed imaging equipment and larger operating tables: Currently, Midtown Hospital operates two orthopedic surgery operating rooms that are undersized. These rooms cannot accommodate the imaging equipment and larger operating tables that are required for more complex total joint replacement procedures such as

joint replacement, which are important and growing needs for an aging population. The current standard for orthopedic operating rooms is approximately 550 to 600 square feet. Midtown Hospital's orthopedic operating rooms measure approximately 333 square feet and do not provide adequate space. Similarly, four orthopedic operating rooms at West Hospital measure approximately 400 square feet and do not provide adequate space.

- Improve quality of care: Creating a center of excellence and consolidating the total joint replacement programs will improve the overall quality of total joint replacement care provided by both Midtown Hospital and West Hospital. The improvements in patient flow with total joint replacement surgery located on a single floor will enhance the patient experience. The "single floor experience" will allow Saint Thomas Health to improve staff collaboration and care coordination throughout the patient's entire episode of care from admissions to discharge. In addition, with larger operating rooms, total joint replacement surgeons will be able to perform more procedures that are complex by having the benefits of needed imaging equipment and larger operating tables in the operating rooms.

EXISTING RESOURCES: Currently, Midtown Hospital offers a continuum of surgical services, including total joint replacement surgery, and it will continue to do so. The proposed project will not result in Midtown Hospital terminating any services; it will only result in the consolidation and enhancement of its total joint replacement operating rooms and joint replacement program.

PROJECT COST: The total estimated cost of the proposed project is $25,832,609. Project costs include $15,155,862 for renovation (includes demolition and related construction costs) of 94,337 square feet ($142.58 per square foot). The cost per square foot is reasonable when compared to other Tennessee projects and is discussed later in the application.

FUNDING: Midtown Hospital will fund the project through centralized and unrestricted cash reserves held by Saint Thomas Health.

FINANCIAL FEASIBILITY: Midtown Hospital expects that construction and renovations will be completed and the project will be operational by September 2015. Projections for FY2016 and FY2017 indicate that the project is financially feasible. As explained below, this project is being proposed in order to improve access to care, economic efficiencies and quality of care without increasing charges to government and third-party payors.

STAFFING: This project will require only a modest increase in staff, approximately 9.7 new FTEs from the community. The majority of the increase at Midtown Hospital will include the relocation of approximately 35 FTEs now at West Hospital to Midtown Hospital. Midtown Hospital's salaries and wages are competitive with the market. Midtown Hospital has a history of successfully recruiting and retaining professional and administrative staff.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

RESPONSE: This project involves renovation to build a center of excellence for total joint replacement services that includes a ten room operating suite for consolidation of joint replacement programs for Saint Thomas Health's two Nashville hospitals – West and Midtown. This project also capitalizes on the strengths of two award-winning total joint replacement programs.

Midtown Hospital has 26 operating rooms, including two orthopedic operating rooms used primarily for joint replacement surgery and fracture surgery. These operating rooms will be relocated to a new total joint replacement surgery suite on the eighth floor.[1]

The operating room suite at Midtown Hospital will be a replacement of existing operating rooms at Midtown Hospital and West Hospital and will not result in an increase in the current number of operating rooms at both Midtown Hospital and West Hospital.

To stage the project, it will be necessary to:

- Renovate two existing nursing floors of the hospital, both located on the eighth floor but in interconnected towers, to create 62 private inpatient beds dedicated to total joint replacement services. Midtown Hospital will redistribute patients currently cared for on these nursing floors to the fifth and sixth floors of the hospital and, therefore, the hospital's licensed bed capacity will not change.
- Create a PACU with 12 private bays and a Prep/Recovery area with 20 private bays on the eighth floor, dedicated to total joint replacement surgery services.
- Resize and relocate two existing ORs on the eighth floor of Midtown Hospital (increasing the size from 333 square feet each to 585 square feet each).
- Create a new central sterile processing center in the basement and connected to the eighth floor via a dedicated elevator bank.

The ten operating rooms will measure approximately 585 square feet each. The PACU will measure approximately 90 square feet per bed and the Prep/Recovery will measure approximately 120 square feet per bed.

[1] These two operating rooms will be used for storage within the sterile OR environment until such time that a more appropriate use for the space is determined.

The total estimated cost of the proposed project is $25,832,609. Project costs include $15,155,862 for renovation (includes demolition and related construction costs) of 94,337 square feet ($142.58 per square foot). The cost per square foot is reasonable when compared to other Tennessee projects and is discussed later in the application.

No temporary relocation is required.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

RESPONSE: The proposed project does not affect the total bed complement at the hospital. The relocation of patients from the eighth floor to the fifth and sixth floors of the hospital will allow for the consolidation of 62 private inpatient beds dedicated to total joint replacement services on the eighth floor, contiguous to the proposed total joint replacement operating rooms, PACU and Prep/Recovery area.

Square Footage Exhibit

Unit/Dept.	Existing Location	Existing Sq. Ft.	Temporary Location	Proposed Final Location	Proposed Final Sq. Footage			Proposed Final Cost/Sq. Ft.		
					Renovated	New	Total	Renovated	New	Total
OR #1 - Class C, Major	4th Floor	333	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #2 - Class C, Major	4th Floor	333	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #3 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #4 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #5 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #6 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #7 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #8 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #9 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #10 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR Support	N/A	N/A	N/A	8th Floor	10,900	N/A	10,900	$200	N/A	$200
PACU/Support	N/A	N/A	N/A	8th Floor	4,162	N/A	4,162	$290	N/A	$290
Prep/Recovery Support	N/A	N/A	N/A	8th Floor	10,200	N/A	10,200	$275	N/A	$275
Central Sterile	N/A	N/A	N/A	Basement Level	3,750	N/A	3,750	$300	N/A	$300
5 Central Patient Unit	5 Central	16,750	N/A	5 Central	16,750	N/A	16,750	$30	N/A	$30
6 Central Patient Unit	6 Central	16,750	N/A	6 Central	16,750	N/A	16,750	$30	N/A	$30
8 Kidd Patient Unit	8 Kidd	18,750	N/A	8 Kidd	18,750	N/A	18,750	$53	N/A	$53
Registration/PAT/Education	N/A	N/A	N/A	1st Floor - North Tower	5,625	N/A	5,625	$150	N/A	$150
Unit/Dept GSF Sub-Total		54,516	N/A		92,737	N/A	92,737	$140.73	N/A	$140.73
Mechanical/Electrical GSF	Mechanical Penthouse		N/A							
Circulation/Structure GSF	Central Lobby - Corridor Upgrades	1,600	N/A	Central Lobby	1,600		1,600	$250	N/A	$250
Total GSF		54,516	N/A		94,337		94,337	$142.58	N/A	$142.58

Note: Does not include demolition and construction contingency.

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

RESPONSE: Not applicable. Midtown Hospital is not requesting new services or additional pieces of major medical equipment.

D. Describe the need to change location or replace an existing facility.

RESPONSE: This project does not involve the relocation or replacement of an entire facility, but the realignment of operating rooms at Midtown Hospital and West Hospital to develop a total joint replacement center of excellence at Midtown Hospital.

Currently, the operating rooms that Midtown Hospital utilizes primarily for joint replacement are not located in a single area with other related inpatient services. This creates operational problems with patient flow and staff productivity. In addition, the operating rooms are undersized, which does not allow the hospital's orthopedic surgeons to perform complex procedures that require imaging equipment and larger operating tables in the operating room. Relocating the orthopedic surgery operating rooms to a self-contained total joint replacement surgery suite with dedicated PACU and Prep/Recovery will offer a number of important benefits to the patient, physician and the hospital.

The intra-facility consolidation will address the current operational problems that arise with having the operating rooms dispersed in multiple locations. In addition, relocating the operating rooms will allow Midtown Hospital to continue to provide orthopedic surgery services in the existing operating rooms while the project is under development. At the completion of the project, Midtown Hospital will be able to make a smooth and seamless transition from the old operating rooms to the new total joint replacement surgery suite.

The inter-facility consolidation with West Hospital represents the integration of separate total joint replacement programs across two hospitals. The project capitalizes on the strengths of two award-winning total joint replacement programs. Benefits include improved alignment with physicians across two campuses in such areas as:

- Access to aggregated data and performance information

- Unified patient education to promote quality outcomes
- Cost containment on supplies, equipment and vendor selection
- Potential participation in bundled payments, including but not limited to CMS Bundled Payments for Care Improvement

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

   a. Describe the new equipment, including:
      1. Total cost; (As defined by Agency Rule).
      2. Expected useful life;
      3. List of clinical applications to be provided; and
      4. Documentation of FDA approval.

   b. Provide current and proposed schedules of operations.

RESPONSE: Not applicable, as Midtown Hospital is not proposing to acquire any single piece of major medical equipment that exceeds $1.5 million or is a MRI, PET, extracorporeal lithotripter or linear accelerator.

2. For mobile major medical equipment:

   a. List all sites that will be served;
   b. Provide current and/or proposed schedule of operations;
   c. Provide the lease or contract cost.
   d. Provide the fair market value of the equipment; and
   e. List the owner for the equipment.

RESPONSE: Not applicable.

3. Indicate applicant's legal interest in equipment (i.e., purchase, lease, etc.). In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

RESPONSE: Not applicable.

III. **(A)** Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must include**:

1. Size of site (***in acres***);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

RESPONSE: Please see **Attachment B, III.(A) (Tab 7)** that depicts the 38-acre site.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

RESPONSE: Midtown Hospital is conveniently located in Nashville just off State Route 70 near two Interstate Highways, I-40/65 and I-440. The hospital is accessible via public transportation services offered by the Nashville Metro Transit Authority, providing direct access to the hospital. The hospital is within 10 miles of the Nashville International Airport.

Please see **Attachment B, III.(B).1 (Tab 8)** for a map depicting the service area and the thoroughfares that connect each county to the proposed site, as well a map of the Nashville MTA service.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

RESPONSE: Please see **Attachment B, IV (Tab 9)** for the floor plan schematics.

V. For a Home Health Agency or Hospice, identify:

1. Existing service area by County;
2. Proposed service area by County;
3. A parent or primary service provider;
4. Existing branches; and
5. Proposed branches.

RESPONSE: Not applicable. The project does not involve a Home Health Agency or Hospice.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. Please type each question and its response on an 8 1/2" x 11" white paper. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

   a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

   RESPONSE: One category is applicable to the project and is addressed below.

   CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

   1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

      RESPONSE: Not applicable. The Midtown Hospital total joint replacement services project does not include the addition of beds, services or medical equipment.

   2. For relocation or replacement of an existing licensed health care institution:

      a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

      b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

      RESPONSE: Not applicable. The Midtown Hospital total joint replacement services project does not include the relocation or replacement of an existing licensed health care institution.

3. For renovation or expansions of an existing licensed health care institution:

   a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

   RESPONSE: Midtown Hospital provides a wide range of surgical services, including orthopedic surgery services, and it will continue to do so in the future. Today, Midtown Hospital operates 26 operating rooms, including 2 dedicated cardiac operating rooms.[2] Over the past three years (2010 to 2012), the hospital has accounted for, on average, almost 16,000 surgical encounters.

   Total joint replacement surgery programs at both Midtown Hospital and West Hospital are comprehensive service lines that have received regional recognition for quality and overall excellence. The orthopedic program is ranked number one in Tennessee and among the top five for orthopedics nationally. The service line includes services for the foot and ankle, joint replacement, sports medicine, hand and upper extremity, general orthopedics, spine, and rehabilitation.

   The joint replacement programs are especially strong, led by a team of joint replacement specialists including surgeons, orthopedic certified nurses, patient care technicians, case managers and physical therapists. The orthopedic surgeons have historically been leaders and innovators in joint replacement, having developed some of the first implants and surgical protocols. In addition, the orthopedic surgeons have been active participants in research programs and the design of new technology for joint replacement. Joint replacement services include procedures for shoulder replacements, hip replacements and knee replacements. The hospitals provide free public seminars on a range of topics related to joint pain.

   This project represents developing a center of excellence for consolidation of total joint replacement programs across Saint Thomas Health's two Nashville hospitals.

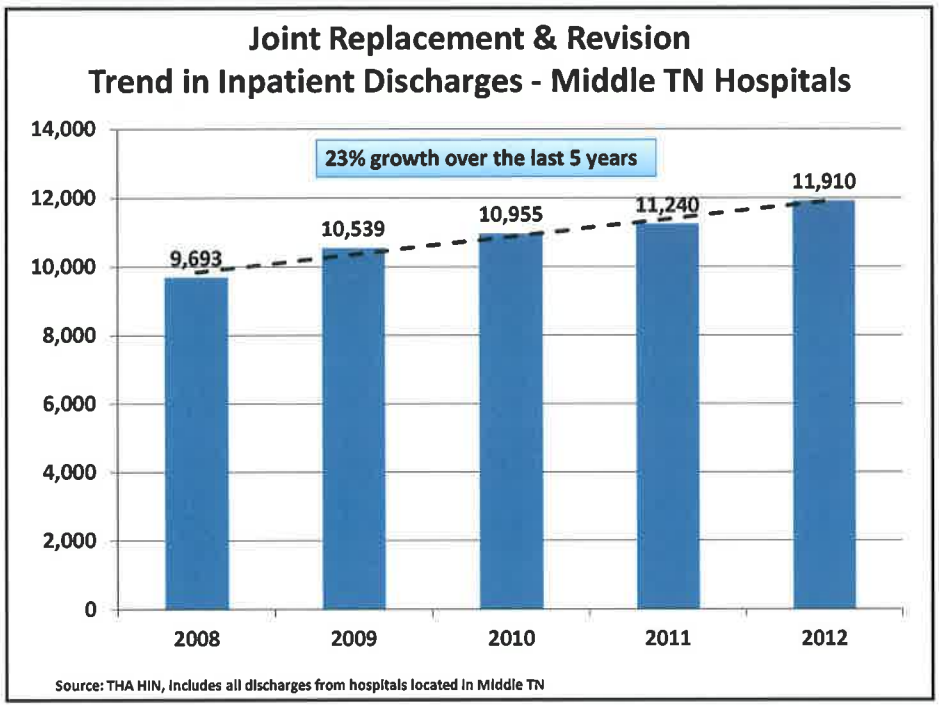
   To stage the project, it will be necessary to:

   - Renovate two existing nursing floors of the hospital, both located on the eighth floor but in interconnected towers, to create 62 private inpatient beds dedicated to total joint replacement services. Midtown Hospital will redistribute the displaced beds on these nursing floors to the fifth and sixth floors of the hospital and, therefore, the hospital's licensed bed capacity will not change.
   - Create a PACU with 12 private bays and a Prep/Recovery area with 20 private bays on the eighth floor, dedicated to total joint replacement surgery services.
   - Resize and relocate two existing ORs on the eighth floor of Midtown Hospital (increasing the size from 333 square feet each to 585 square feet each).
   - Create a new central sterile processing center in the basement and connected to the eighth floor via a dedicated elevator bank.

   Saint Thomas Health, Midtown Hospital and West Hospital all expect to achieve operational efficiencies and quality enhancements from this project.

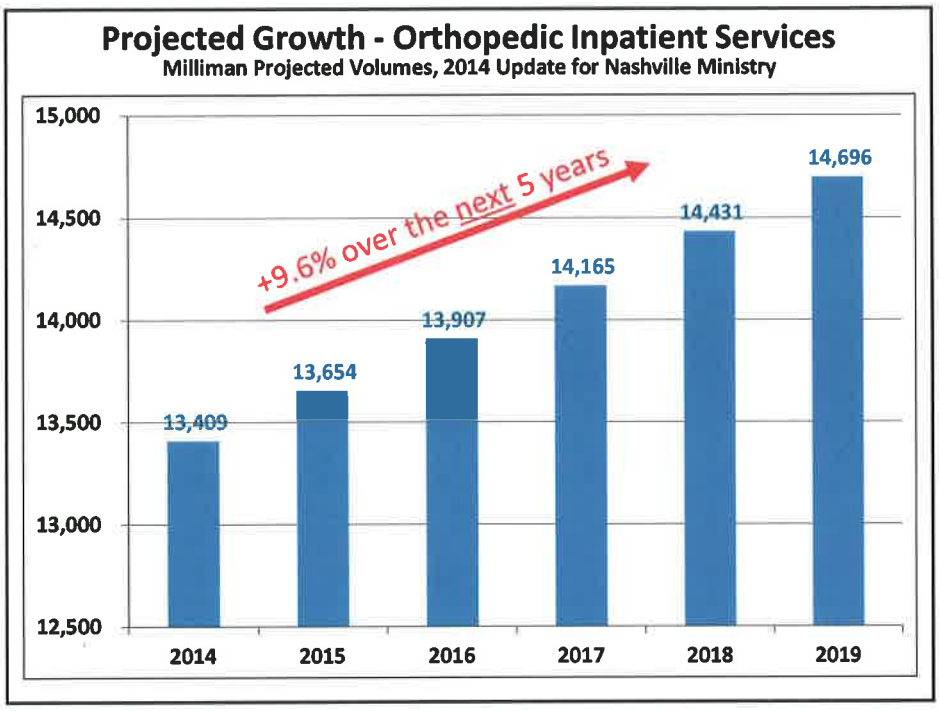
[2] 2008 - 2012 ASTC JAR references to 26 inpatient operating rooms plus either 2 outpatient or 2 cardiac operating rooms are incorrect. The correct description should be 26 operating rooms *including* 2 dedicated open heart operating rooms (and 0 dedicated outpatient operating rooms).

Historical growth in joint replacement and revision surgery in the area[3] averaged 23% over the past five years. Thus, there has been a growing demand for the services proposed by Midtown Hospital in this project.



Although actuarial projections suggest a lower rate of growth during the next five years, 9.6 % is still a very robust projection. Thus, there can be expected to be a growing future demand for the services proposed by Midtown Hospital in this project as well.

[3] The top ten area hospitals accounted for 78% of the total volume. Specific hospitals cannot be quoted due to database usage agreements.



b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

RESPONSE: Saint Thomas Health seeks approval to develop a center of excellence for total joint replacement services. This project will improve operational efficiency across the health system, provide ORs that are large enough to accommodate imaging equipment and larger operating tables and enhance the overall quality of total joint replacement surgery services. Achieving these objectives was instrumental in the decision to proceed with this project at Midtown Hospital.

- Improve patient flow and operational efficiency: The total joint replacement operating rooms at Saint Thomas Health are not centrally located, which creates poor patient flow and operational inefficiencies across the hospital campuses. Because the operating rooms are not in a single location, it is difficult to maximize physician and staff productivity as well as provide efficient and seamless patient flow. By consolidating the total joint replacement operating rooms on the eighth floor of the hospital with a dedicated PACU and Prep/Recovery, Midtown Hospital will be able to enhance operational efficiency and staff productivity. In addition, inpatient surgical patients will be cared for on two adjacent nursing units, which should further enhance patient flow and care coordination.

- Provide operating rooms large enough to accommodate needed imaging equipment and larger operating tables: Currently, Midtown Hospital operates two orthopedic surgery operating rooms that are undersized. These rooms cannot accommodate the imaging equipment and larger operating tables that are required for more complex total joint replacement procedures such as joint replacement, which are important and growing needs for an aging population. The current standard for orthopedic operating rooms is approximately 550 to 600 square feet. Midtown Hospital's orthopedic operating rooms measure

approximately 333 square feet and do not provide adequate space. Similarly, four orthopedic operating rooms at West Hospital measure approximately 400 square feet and do not provide adequate space.

- Improve quality of care: Consolidating the total joint replacement joint replacement operating rooms at Midtown Hospital and West Hospital into a single total joint replacement surgery suite on the eighth floor of Midtown Hospital will improve the overall quality of total joint replacement care provided by both Midtown Hospital and West Hospital. The improvements in patient flow with total joint replacement surgery located on a single floor will enhance the patient experience. The "single floor experience" will allow Saint Thomas Health to improve staff collaboration and care coordination throughout the patient's entire episode of care from admissions to discharge. In addition, with larger operating rooms, Midtown Hospital's total joint replacement surgeons will be able to perform more procedures that are complex by having the benefits of needed imaging equipment and larger operating tables in the operating rooms.

Although studied, Saint Thomas Health did not consider renovating and enlarging the existing operating rooms at West Hospital to be a more viable option. Although major construction is now taking place at West Hospital, the total joint replacement services project would further disrupt services at West Hospital and leave excess square footage at Midtown Hospital.

New construction of the total joint replacement services project at Midtown Hospital was also considered. However, this current project was considered to be the superior plan. Midtown Hospital anticipated the cost of new construction at Midtown Hospital to be higher than the costs of the proposed project. In addition, new construction would not necessarily allow the total joint replacement surgery suite to be contiguous to an inpatient unit. This option allows Midtown Hospital to create a single floor experience for its total joint replacement patients and gain the advantage of improved staff communication and care coordination that comes from the surgical suite and inpatient unit being on the same floor and contiguous.

Midtown Hospital's proposal to renovate the eighth floor to accommodate consolidated total joint replacement services from two hospital campuses is the most responsible plan for addressing the current facility limitations. The project addresses all of the deficiencies of both Midtown Hospital's and West Hospital's existing total joint replacement operating rooms and does so in a cost-effective approach.

b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

RESPONSE: Not applicable. This project does not include a change of site for a health care institution.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

RESPONSE: For more than 90 years, Midtown Hospital has been devoted to physical, emotional and spiritual healing. Midtown Hospital is the largest not-for-profit community hospital in Middle Tennessee, licensed for 683 acute and rehab care beds. Routine facility refurbishment is a necessary part of maintaining quality hospital services. This is especially critical in such key service line areas as orthopedic surgery and total joint replacement services. This project will

improve operational efficiency across the health system, provide ORs that are large enough to accommodate imaging equipment and larger operating tables and enhance the overall quality of total joint replacement surgery services. Achieving these objectives was instrumental in the decision to proceed with this project at Midtown Hospital. Specifically, Midtown Hospital's proposal to consolidate and expand its total joint replacement services will help accomplish the following goals:

- Improve operational efficiency by consolidating similar services from two hospital campuses (Midtown Hospital and West Hospital) at a single location (Midtown Hospital)
- Improve operational efficiency by enhancing patient flow and increasing staff productivity
- Improve quality of care by increasing the square footage of several existing operating rooms to accommodate needed imaging equipment and operating room tables for complex total joint replacement surgery cases
- Improve access to total joint replacement services

These goals are also similar to the Five Principals for Achieving Better Health as articulated in the 2009 State Health Plan.

1. Healthy Lives. This project will improve the health of Tennesseans by improving clinical outcomes with modern total joint replacement surgery facilities and providing a safer environment for patients by improving patient flow and care coordination.

2. Access to Care. This project will improve access to Saint Thomas Health's total joint replacement services and allow Midtown Hospital to provide a broader range of complex surgeries that require in-room imaging equipment and larger operating tables.

3. Economic Efficiencies. This project will achieve operational efficiencies by replacing old, decentralized operating rooms with newer, state-of-the-art rooms that Midtown Hospital will operate within a centralized total joint replacement surgery suite with dedicated PACU and Prep/Recovery. Patient flow and care coordination will be enhanced under a "single floor" concept that places total joint replacement surgical services and total joint replacement inpatient care on the same floor and contiguous to each other. Similarly, relocating total joint replacement operating rooms from West Hospital while it is undergoing extensive renovations and construction will also enhance patient flow and coordination under a "single site" concept.

4. Quality of Care. In addition to the facility upgrades mentioned above, Midtown Hospital will continue to improve its quality of care through the adoption of best practices and data-driven evaluation. Realignment of the total joint replacement surgery functions including admission, prep, procedure, recovery and discharge functions all on one floor is evidence of such efforts. Realignment and consolidation of the total joint replacement surgery functions from two hospital campuses to a single hospital campus is another example.

5. Health Care Workforce. Midtown Hospital is committed to the recruitment and retention of a sufficient and quality health care workforce. In recent years, Midtown Hospital was named in Modern Healthcare's Best Places to Work in Healthcare and received the Tennessee Nurses Association's Outstanding Employer Award.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

RESPONSE: Based on historical patient origin data, Midtown Hospital's service area for this project is comprised of 12 counties. As reported in the hospital's FY2012 patient origin data, this 12 county area represents 89.5 % of Midtown Hospital's inpatient discharges. Please see **Attachment C, Need – 3 (Tab 10)** for a map and data (past three years) related to the service area.

4. A. Describe the demographics of the population to be served by this proposal.

RESPONSE: Midtown Hospital's primary service area is comprised of the 12 counties located in middle Tennessee, listed below.

Cheatham	Humphreys	Rutherford
Davidson	Maury	Sumner
Dickson	Montgomery	Williamson
Hickman	Robertson	Wilson

Between 2014 and 2019, the population of the service area is projected to increase by 6.8%, or by 130,604 residents. This represents an annual growth rate of 1.3% and is greater than the projected growth rate of the state within that same five-year period, which is 0.7% annually, or 3.8% total growth, and almost twice the rate of growth of the United States as a whole. Please see **EXHIBIT 1,** which illustrates the projected changes in population of the service area between 2014 and 2019 and denotes population growth within the state of Tennessee, and the United States.

EXHIBIT 1
TOTAL POPULATION PROJECTIONS

	Total Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	664,655	709,211	44,556	1.3%	6.7%
Subtotal PSA	**664,655**	**709,211**	**44,556**	**1.3%**	**6.7%**
Secondary Service Area					
Cheatham	39,492	40,383	891	0.4%	2.3%
Dickson	50,804	52,439	1,635	0.6%	3.2%
Hickman	23,845	23,293	-552	-0.5%	-2.3%
Humphreys	18,083	17,812	-271	-0.3%	-1.5%
Maury	82,782	85,551	2,769	0.7%	3.3%
Montgomery	194,121	216,483	22,362	2.2%	11.5%
Robertson	67,218	68,763	1,545	0.5%	2.3%
Rutherford	282,183	303,410	21,227	1.5%	7.5%
Sumner	169,601	179,830	10,229	1.2%	6.0%
Williamson	199,481	216,691	17,210	1.7%	8.6%
Wilson	122,225	131,228	9,003	1.4%	7.4%
Subtotal SSA	**1,249,835**	**1,335,883**	**86,048**	**1.3%**	**6.9%**
Total Service Area	**1,914,490**	**2,045,094**	**130,604**	**1.3%**	**6.8%**
Tennessee	6,531,577	6,778,877	247,300	0.7%	3.8%
United States	317,199,353	328,309,464	11,110,111	0.7%	3.5%

SOURCE: NIELSEN, INC.

The anticipated growth in the 65 and older population within the service area is much greater; nearly four times that of the total growth. Between 2014 and 2019, projections indicate that the senior population will increase 26.6%, or by 59,664 residents. For Tennessee, projections are that the total five-year growth within this age cohort will be 19.3%, for the United States, 18.0%. Because seniors are among the highest users of healthcare services, such an explosive growth rate foretells the need for Midtown Hospital to anticipate increasing demand for services as result of this growth as well as that of the general population. Please see **EXHIBIT 2**.

EXHIBIT 2
65 AND OLDER POPULATION PROJECTIONS

	65+ Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	75,873	95,113	19,240	4.6%	25.4%
Subtotal PSA	**75,873**	**95,113**	**19,240**	**4.6%**	**25.4%**
Secondary Service Area					
Cheatham	5,146	6,500	1,354	4.8%	26.3%
Dickson	7,467	8,872	1,405	3.5%	18.8%
Hickman	3,747	4,247	500	2.5%	13.3%
Humphreys	3,454	3,825	371	2.1%	10.7%
Maury	12,166	14,739	2,573	3.9%	21.1%
Montgomery	17,020	22,348	5,328	5.6%	31.3%
Robertson	8,908	10,715	1,807	3.8%	20.3%
Rutherford	26,622	34,719	8,097	5.5%	30.4%
Sumner	24,216	30,018	5,802	4.4%	24.0%
Williamson	22,885	31,160	8,275	6.4%	36.2%
Wilson	17,206	22,118	4,912	5.2%	28.5%
Subtotal SSA	**148,837**	**189,261**	**40,424**	**4.9%**	**27.2%**
Total Service Area	**224,710**	**284,374**	**59,664**	**4.8%**	**26.6%**
Tennessee	968,443	1,155,791	187,348	3.6%	19.3%
United States	45,157,410	53,278,626	8,121,216	3.4%	18.0%

SOURCE: NIELSEN, INC.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

RESPONSE: Midtown Hospital has a history of providing high quality healthcare that is accessible to all segments of the community. It provides services without regard to gender, race, socio-economic status, or ability to pay, and participates in the Medicare and TennCare programs.

In 2014, the 65 and older population will account for 11.7% of the total population in the service area. As a major demographic subgroup of Midtown Hospital's patient base, seniors will continue

to expect of Midtown Hospital the same level of service while becoming an increasingly larger segment of the total service area population, with 2019 projections placing the 65 and older population at 13.9% of the total service area population.

The female population will represent 51.1% of the total population in the service area by 2019. As shown in **EXHIBIT 3**, the female population is expected to grow at the same annual rate for both sexes in service area, 1.3% per year.

EXHIBIT 3
FEMALE POPULATION PROJECTIONS

	Female Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	342,524	364,539	22,015	1.3%	6.4%
Subtotal PSA	**342,524**	**364,539**	**22,015**	**1.3%**	**6.4%**
Secondary Service Area					
Cheatham	19,822	20,316	494	0.5%	2.5%
Dickson	25,883	26,708	825	0.6%	3.2%
Hickman	11,335	11,070	-265	-0.5%	-2.3%
Humphreys	9,179	9,034	-145	-0.3%	-1.6%
Maury	42,722	44,068	1,346	0.6%	3.2%
Montgomery	98,791	110,109	11,318	2.2%	11.5%
Robertson	34,136	34,943	807	0.5%	2.4%
Rutherford	142,924	153,694	10,770	1.5%	7.5%
Sumner	86,873	92,086	5,213	1.2%	6.0%
Williamson	102,093	110,955	8,862	1.7%	8.7%
Wilson	62,340	66,975	4,635	1.4%	7.4%
Subtotal SSA	**636,098**	**679,958**	**43,860**	**1.3%**	**6.9%**
Total Service Area	**978,622**	**1,044,497**	**65,875**	**1.3%**	**6.7%**
Tennessee	3,345,908	3,468,589	122,681	0.7%	3.7%

SOURCE: NIELSEN, INC.

EXHIBITS 4-6 illustrate the racial composition of the Midtown Hospital service area. By 2019, the white population will comprise 74.5% of the total population of the service area, while the black population will account for 16.2% and other races, 9.3%.

EXHIBIT 4
WHITE POPULATION PROJECTIONS

	White Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	408,515	436,103	27,588	1.3%	6.8%
Subtotal PSA	**408,515**	**436,103**	**27,588**	**1.3%**	**6.8%**
Secondary Service Area					
Cheatham	37,203	37,305	102	0.1%	0.3%
Dickson	46,154	46,949	795	0.3%	1.7%
Hickman	21,814	20,888	-926	-0.9%	-4.2%
Humphreys	17,015	16,521	-494	-0.6%	-2.9%
Maury	67,862	69,692	1,830	0.5%	2.7%
Montgomery	137,049	151,690	14,641	2.1%	10.7%
Robertson	57,996	58,320	324	0.1%	0.6%
Rutherford	217,598	229,477	11,879	1.1%	5.5%
Sumner	149,058	155,573	6,515	0.9%	4.4%
Williamson	175,644	186,957	11,313	1.3%	6.4%
Wilson	107,559	113,849	6,290	1.1%	5.8%
Subtotal SSA	**1,034,952**	**1,087,221**	**52,269**	**1.0%**	**5.1%**
Total Service Area	**1,443,467**	**1,523,324**	**79,857**	**1.1%**	**5.5%**
Tennessee	5,008,888	5,123,236	114,348	0.5%	2.3%
United States	226,254,684	229,546,283	3,291,599	0.3%	1.5%

SOURCE: NIELSEN, INC.

EXHIBIT 5
BLACK POPULATION PROJECTIONS

	Black Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	179,871	185,690	5,819	0.6%	3.2%
Subtotal PSA	**179,871**	**185,690**	**5,819**	**0.6%**	**3.2%**
Secondary Service Area					
Cheatham	961	1,516	555	9.5%	57.8%
Dickson	2,370	2,815	445	3.5%	18.8%
Hickman	1,296	1,545	249	3.6%	19.2%
Humphreys	555	685	130	4.3%	23.4%
Maury	10,266	10,447	181	0.4%	1.8%
Montgomery	37,609	42,613	5,004	2.5%	13.3%
Robertson	5,304	5,834	530	1.9%	10.0%
Rutherford	36,892	41,893	5,001	2.6%	13.6%
Sumner	11,857	13,942	2,085	3.3%	17.6%
Williamson	10,334	13,670	3,336	5.8%	32.3%
Wilson	8,518	10,138	1,620	3.5%	19.0%
Subtotal SSA	**125,962**	**145,098**	**19,136**	**2.9%**	**15.2%**
Total Service Area	**305,833**	**330,788**	**24,955**	**1.6%**	**8.2%**
Tennessee	1,102,940	1,163,366	60,426	1.1%	5.5%
United States	40,263,108	42,033,755	1,770,647	0.9%	4.4%

SOURCE: NIELSEN, INC.

EXHIBIT 6
"OTHER" POPULATION PROJECTIONS

	Other Population				
	2014	2019	Abs Chg	Ann % Chg	Abs % Chg
Primary Service Area					
Davidson	76,269	87,418	11,149	2.8%	14.6%
Subtotal PSA	**76,269**	**87,418**	**11,149**	**2.8%**	**14.6%**
Secondary Service Area					
Cheatham	1,328	1,562	234	3.3%	17.6%
Dickson	2,280	2,675	395	3.2%	17.3%
Hickman	735	860	125	3.2%	17.0%
Humphreys	513	606	93	3.4%	18.1%
Maury	4,654	5,412	758	3.1%	16.3%
Montgomery	19,463	22,180	2,717	2.6%	14.0%
Robertson	3,918	4,609	691	3.3%	17.6%
Rutherford	27,693	32,040	4,347	3.0%	15.7%
Sumner	8,686	10,315	1,629	3.5%	18.8%
Williamson	13,503	16,064	2,561	3.5%	19.0%
Wilson	6,148	7,241	1,093	3.3%	17.8%
Subtotal SSA	**88,921**	**103,564**	**14,643**	**3.1%**	**16.5%**
Total Service Area	**165,190**	**190,982**	**25,792**	**2.9%**	**15.6%**
Tennessee	419,749	492,275	72,526	3.2%	17.3%
United States	50,681,561	56,729,426	6,047,865	2.3%	11.9%

SOURCE: NIELSEN, INC.

The service area counties as a whole have a Median Household Incomes higher than the state of Tennessee. The annual growth in median household income is again comparable to that of the state, virtually flat. Please see **EXHIBIT 7.**

EXHIBIT 7
SERVICE AREA MEDIAN HOUSEHOLD INCOME

	Median Household Income	
	2014	2019
Primary Service Area		
Davidson	$44,608	$47,370
Subtotal PSA	**$44,608**	**$47,370**
Secondary Service Area		
Cheatham	$52,529	$43,347
Dickson	$42,790	$35,460
Hickman	$43,762	$38,321
Humphreys	$41,576	$31,970
Maury	$41,360	$42,625
Montgomery	$51,464	$63,836
Robertson	$48,438	$40,881
Rutherford	$57,220	$65,324
Sumner	$53,501	$59,146
Williamson	$86,706	$94,370
Wilson	$59,684	$63,619
Subtotal SSA	**$52,639**	**$52,627**
Total Service Area	**$51,970**	**$52,189**
Tennessee	$43,390	$43,130

SOURCE: NIELSEN, INC.

Median household income data were obtained from Nielsen (f/k/a Claritas). Nielsen presents itself as a leading global information and measurement company, providing market research and data to, among others, Fortune 500 corporations. Nielsen demographic data are widely accepted in the healthcare industry.

Median household income data, above, were verified. No discrepancies were found from the sources reports to the CON application. In addition, trends in average household income follow the same patterns as median household income. Nielsen was contacted for clarification of their methodology and results. A response is still pending.

Please note that of the 15 geographic areas examined in **EXHIBIT 7**, seven actually project an increase in median household income – Davidson County, Maury County, Montgomery County, Rutherford County, Sumner County, Williamson County and Wilson County.

As a possible alternative, the Tennessee Department of Revenue website was consulted. No income projections were provided. However, a link to University of Tennessee Knoxville economic forecasts through 2014 did suggest income growth statewide. See http://cber.bus.utk.edu/tefs/spr13.pdf, PDF page 19.

Regardless of the projected trend in income, Midtown Hospital's proposed project is not significantly dependent upon income projections.

In terms of the TennCare population, 14.8% of the service area population is enrolled compared to 18.5% for the state overall. Please see **Attachment C, Need – 4 (Tab 11)**.

As a member of Ascension Health, the nation's largest Catholic healthcare system, Midtown Hospital continues to build and strengthen sustainable collaborative efforts that benefit the health of individuals, families, and society as a whole. The goal of Midtown Hospital is to perpetuate the healing mission of the church. Midtown Hospital furthers this goal through delivery of patient services, care to the elderly, indigent, and impoverished persons/families, patient education and health awareness programs for the community, and medical research. Our concern for the human life and dignity of all persons leads the organization to provide medical services to all people in the community without regard to the patient's race, creed, national origin, economic status, or ability to pay.

Midtown collaborates with many community organizations to improve the community health and expand access to health care including support for the Faith Family Clinic, an independent faith-based clinic for the poor located on the hospital campus at no cost to the clinic. In addition, Midtown continues to be active in networking with other healthcare providers in the Nashville area as part of the Bridges to Care (BTC) program, which links uninsured residents of Nashville to a network of some 35 safety net primary care, dental, mental health, and substance abuse clinics that serve patients based on their ability to pay. The Baptist UT (University of Tennessee) Resident Clinic housed on the Baptist campus is a BTC referral clinic. BTC also provides help with prescription medications and transportation. In the last year, the hospital's Health Ministry has encouraged physician participation in the Bridges to Care program. This program, administered by the Nashville Academy of Medicine, links BTC participants to physician specialists upon referral by their primary care physician. Midtown Hospital provides the appropriate inpatient care services as a participant of this program.

Midtown Hospital also participates in a program developed by Saint Thomas Health to assist in the provision of vital medications to those challenged by poverty called the Dispensary of Hope Program. This program started from a network of physician offices donating sample medications and has evolved to obtaining huge donations of medications from pharmaceutical companies and wholesale distributors. The expansion of the Dispensary as a region-wide program now allows broader and cost effective distribution of medications to persons who are poor through a collaborative network of pharmacies at existing healthcare providers. Medications are shared with safety net clinic sites and the Bridges to Care program, as well as with many of the transplant patients of the hospital who would otherwise not be able to afford costly pharmaceutical post-transplant care. The Dispensary has recently added a 90 day mail supply capability, which greatly expands its ability to respond to those in need.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

RESPONSE: No new services or equipment are proposed. Saint Thomas Health seeks approval for the realignment of its total joint replacement services across Midtown Hospital and West Hospital to a single dedicated floor at Midtown Hospital. This project will improve operational efficiency across the health system, provide ORs that are large enough to accommodate imaging equipment and larger operating tables and enhance the overall quality of total joint replacement surgery services.

Achieving these objectives was instrumental in the decision to proceed with this project at Midtown Hospital.

Within Midtown Hospital's 12-county primary and secondary service area, 23 hospitals provide surgical services.

Of these 23 facilities, Midtown Hospital and six other providers in Davidson County complete the majority of the service area's major total joint replacement surgeries[4]. Please see **Exhibit 8** below which details historical surgical volumes at these seven hospitals. Over the past three years, Midtown Hospital has been one of the top two or three Nashville hospitals in terms of total surgical volume as measured by either encounters or procedures. In addition, Midtown Hospital has been one of the most highly utilized surgical services in the Nashville area, averaging 586 encounters and 1,351 procedures per operating room in 2012. Please see **Exhibits 8 and 9**.

[4] Including DRGs 470, 480, 481, and 482.

Exhibit 8
Top Service Area Orthopedic Surgery Providers
Surgical Trends, Total Surgeries, 2010 – 2012

	Inpatient								
	2010			2011			2012		
Facility	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures
Baptist Hospital	26	6,253	21,268	26	9,387	22,875	26	9,526	24,566
Centennial Med Ctr	33	7,131	9,939	37	7,377	10,964	33	7,828	9,853
Saint Thomas Hospital	18	7,624	27,175	18	7,662	25,978	18	7,841	25,923
Skyline Med Ctr	12	2,266	0	12	2,113	2,141	12	2,300	2,278
Southern Hills Med Ctr	10	969	1,246	10	883	1,068	10	1,170	1,471
Summit Med Ctr	0	1,988	2,195	12	2,455	2,611	12	2,217	2,409
Vanderbilt Uni Hosp	61	21,633	43,346	62	22,242	46,436	62	22,140	46,443
	Outpatient								
	2010			2011			2012		
Facility	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures	Rooms	Encounters	Procedures
Baptist Hospital	0	8,291	15,129	2	7,601	14,319	2	6,889	13,265
Centennial Med Ctr	4	3,858	4,566	0	10,817	16,456	4	9,473	15,867
Saint Thomas Hospital	2	3,084	5,852	2	3,580	6,574	2	3,622	6,810
Skyline Med Ctr	0	2,906	0	0	2,769	2,748	0	2,754	2,728
Southern Hills Med Ctr	10	2,344	4,692	10	2,275	2,657	10	2,289	2,972
Summit Med Ctr	0	3,515	4,167	0	2,932	3,525	0	3,137	3,767
Vanderbilt Uni Hosp	6	23,674	39,399	5	25,631	43,705	6	28,604	49,481

Source: Tennessee Joint Annual Reports, 2010 - 2012

Exhibit 9
Inpatient and Outpatient Surgical Utilization per Operating Room
Surgical Trends, Total Surgeries, 2010 – 2012

	Inpatient and Outpatient Utilization per OR								
	2010			2011			2012		
Facility	Rooms	Encounters per OR	Procedures per OR	Rooms	Encounters per OR	Procedures per OR	Rooms	Encounters per OR	Procedures per OR
Baptist Hospital	26	559	1,400	28	607	1,328	28	586	1,351
Centennial Med Ctr	37	297	392	37	492	741	37	468	695
Saint Thomas Hospital	20	535	1,651	20	562	1,628	20	573	1,637
Skyline Med Ctr	12	431	0	12	407	407	12	421	417
Southern Hills Med Ctr	20	166	297	20	158	186	20	173	222
Summit Med Ctr	0	N/A	N/A	12	449	511	12	446	515
Vanderbilt Uni Hosp	67	676	1,235	67	715	1,345	68	746	1,411

Source: Tennessee Joint Annual Reports, 2010 - 2012

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

RESPONSE: Midtown Hospital provides a wide range of surgical services, including orthopedic surgery and total joint replacement services, and it will continue to do so in the future. Today, Midtown Hospital operates 26 inpatient operating rooms and two outpatient operating rooms. Over the past three years (2010 to 2012), the hospital has accounted for, on average, almost 16,000 surgical encounters.

Total joint replacement surgery programs at both Midtown Hospital and West Hospital are comprehensive service lines that have received regional recognition for quality and overall excellence. The orthopedic program is ranked number one in Tennessee and among the top five for orthopedics nationally. The service line includes services for the foot and ankle, joint replacement, sports medicine, hand and upper extremity, general orthopedics, spine, and rehabilitation.

The joint replacement programs are especially strong, led by a team of joint replacement specialists including surgeons, orthopedic certified nurses, patient care technicians, case managers and physical therapists. The orthopedic surgeons have historically been leaders and innovators in joint replacement, having developed some of the first implants and surgical protocols. In addition, the orthopedic surgeons have been active participants in research programs and the design of new technology for joint replacement. Joint replacement services include procedures for shoulder replacements, hip replacements and knee replacements. The hospitals provide free public seminars on a range of topics related to joint pain.

Midtown Hospital and West Hospital perform more than 3,500 joint replacements annually. Please see **Exhibit 10** profiling Midtown Hospital's and West Hospital's surgical volumes over the past three years and projected five years. Please note the shift in cases projected from the West Hospital campus to the Midtown Hospital campus.

Exhibit 10A
Baptist Hospital / Midtown Hospital Surgical Trends and Utilization, 2008 - 2017 (Cases)

IP & OP	Historical				Interim			Year 1	Year 2
	2010	2011	2012	Average	2013	2014	2015	2016	2017
Total Surgery	14,544	16,988	16,415	15,982	15,312	15,025	14,744	16,793	16,858
Joint Replace Surg	1,436	1,419	1,402	1,419	1,429	1,351	1,315	3,632	3,697

Sources: Joint Annual Reports and Baptist Hospital Internal Data

Exhibit 10B
Saint Thomas Hospital / West Hospital Surgical Trends and Utilization, 2008 - 2017 (Cases)

IP & OP	Historical				Interim			Year 1	Year 2
	2010	2011	2012	Average	2013	2014	2015	2016	2017
Total Surgery	10,708	11,242	11,463	11,138	11,688	11,918	12,152	10,140	10,260
Joint Replace Surg	2,074	2,081	2,157	2,104	2,341	2,733	2,792	600	624

Sources: Joint Annual Reports and Baptist Hospital Internal Data

Without consideration for block scheduling, total joint replacement operating room utilization is projected to be 52.1% in Year One / FY2016 and is based on the following assumptions.

- 3,632 joint replacement cases at Midtown Hospital
- 172 minutes per case (624,704 minutes total or 10,412 hours total)
- 10 ORs
- 2,000 hours per OR per year

However, Midtown Hospital proposes to use a block scheduling system to optimize physician time and patient turnaround in the total joint replacement operating rooms. Under this approach, total joint operating room utilization is projected to be 76.0% in Year One / FY2016 and is based on the following assumptions.

- Existing surgeon block schedules for both Midtown Hospital and West Hospital will be utilized for physician preferences and efficiencies
- Existing surgeon block schedules at both Midtown Hospital and West Hospital are kept constant at 2.0 operating rooms per surgeon, and perhaps 2.5 if volume/case mix warrants
- Average length of stay for total joint replacement patients is typically three, four or five days
- Patient recovery is focused on Monday to Friday rehabilitation and physician follow-up, as is customary
- Thus, operating room time is front-loaded into the weekly schedule, as illustrated below
    - Monday 10 ORs 100%
    - Tuesday 10 ORs 100%
    - Wednesday 9.5 ORs 95%
    - Thursday 7.5 ORs 75%
    - Friday 1 OR 10%

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

   - All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
   - The cost of any lease (building, land and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. NOTE: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.
   - The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
   - For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

   RESPONSE: The CON filing fee is calculated at a rate of $2.25 per $1,000 of project costs as reported on Line D.

   No leases are involved with this project.

   Moveable equipment in Line A.8 includes various total joint replacement surgery instruments, a C-arm, a Hanna table, a fracture table, anesthesia machines and a SPD washer.

   No maintenance agreements are included in the project.

   Please see **Attachment C, Economic Feasibility – 1 (Tab 12)** for a letter supporting the construction costs.

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	$1,254,276
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$155,000
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Construction Costs (includes demolition and related)	$15,155,862
6.	Contingency Fund (Owner's Contingency)	$503,651
7.	Fixed Equipment (Not included in Construction Contract)	$5,020,000
8.	Moveable Equipment (List all equipment over $50,000)	$1,666,970
9.	Other (Clinical informatics, etc)	$2,031,850
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land)	
2.	Building only	
3.	Land only	
4.	Equipment (Specify) _____	
5.	Other (Specify) _____	
C.	Financing Costs and Fees:	
1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify)	
D.	Estimated Project Cost (A+B+C)	$25,787,609
E.	CON Filing Fee	$45,000
F.	Total Estimated Project Cost (D+E)	$25,832,609
	TOTAL	$25,832,609

2. Identify the funding sources for this project.
Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

___ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

___ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

___ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants--Notification of intent form for grant application or notice of grant award; or

_X_ E. Cash Reserves **(See Letter - Tab 13; See Cash line - Tab 15, Page 3)**

___ F. Other—Identify and document funding from all other sources.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

RESPONSE: At an average renovation cost of $142.58 per square foot for this project is comparable to other recently approved Tennessee CON projects. **Exhibit 11**, below, lists the average hospital construction cost per square foot for all CON-approved applications for years 2010 through 2012.

EXHIBIT 11
HOSPITAL CONSTRUCTION COST PER SQUARE FOOT
APPROVED PROJECTS, 2010 - 2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$99.12/sq ft	$234.64/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$259.66/sq ft	$235.00/sq ft
3rd Quartile	$249.00/sq ft	$307.80/sq ft	$274.63/sq ft

Source: Tennessee HSDA

4. Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

   RESPONSE: Please refer to the completed charts on pages 38 through 41.

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

   RESPONSE: Based on Year 2 projections (FY2017), the average gross patient charge per total joint replacement procedure is $65,691. The average deduction from gross patient charges, based on contractual allowances and allowances for charity care and bad debt, is approximately 71.0%, resulting in an average net revenue per procedure of approximately $19,022.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July. (Numbers reported in thousands, entire hospital)

		Year 2011	Year 2012	Year 2013
A.	Utilization Data (Patient Days)	113,135	112,163	108,732
B.	Revenue from Services to Patients			
1.	Inpatient Services	$690,544	$780,339	$862,034
2.	Outpatient Services	371,468	408,992	399,432
3.	Emergency Services	64,527	71,046	69,385
4.	Other Operating Revenue (Specify) - Misc.	15,775	29,405	27,821
	Gross Operating Revenue	$1,142,315	$1,289,782	$1,358,672
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$715,893	$806,267	$883,666
2.	Provision for Charity Care	24,972	53,683	36,117
3.	Provisions for Bad Debt	14,368	9,962	21,308
	Total Deductions	$755,234	$869,913	$941,090
NET OPERATING REVENUE		$387,081	$419,869	$417,582
D.	Operating Expenses			
1.	Salaries and Wages	$135,028	$133,380	$127,496
2.	Physician's Salaries and Wages	0	0	0
3.	Supplies	68,938	74,598	77,106
4.	Taxes	0	0	0
5.	Depreciation	17,371	16,425	16,627
6.	Rent	0	0	0

7. Interest, other than Capital	9,899	9,195	8,524
8. Other Expenses (See details below)	135,304	152,984	150,771
Total Operating Expenses	$366,539	$386,582	$380,524
E. Other Revenue (Expenses) - Net (Specify)	$285	$0	$0
NET OPERATING INCOME (LOSS)	$20,827	$33,286	$37,058
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures	$0	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$20,827	$33,286	$37,058

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2011	Year 2012	Year 2013
1. Purchased Services	$30,868	$34,902	$34,181
2. Professional Fees	9,689	10,955	9,588
3. Miscellaneous	94,747	107,127	107,002
4.			
5.			
6.			
7.			
Total Other Expenses	**$135,304**	**$152,984**	**$150,771**

PROJECTED DATA CHART

Give us information for the two (2) years following the completion of this proposal. The fiscal year begins in July. (Numbers reported in thousands, entire hospital)

		Year 2016	Year 2017
A.	Utilization Data (Patient Days)	111,021	111,171
B.	Revenue from Services to Patients		
1.	Inpatient Services	$1,099,971	$1,108,971
2.	Outpatient Services	449,483	447,448
3.	Emergency Services	78,079	82,937
4.	Other Operating Revenue (Specify)	24,408	24,089
	Gross Operating Revenue	$1,651,941	$1,663,445
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$1,106,020	$1,109,629
2.	Provision for Charity Care	38,611	41,291
3.	Provisions for Bad Debt	28,339	30,306
	Total Deductions	$1,172,970	$1,181,226
NET OPERATING REVENUE		$478,971	$482,219
D.	Operating Expenses		
1.	Salaries and Wages	$144,807	$146,255
2.	Physician's Salaries and Wages		
3.	Supplies	91,165	91,594
4.	Taxes		
5.	Depreciation	19,336	19,916
6.	Rent		

7.	Interest, other than Capital	10,207	10,411
8.	Other Expenses (See details below)	165,119	165,169
	Total Operating Expenses	$430,634	$433,345
E.	Other Revenue (Expenses) -- Net (Specify)	$0	$0
NET OPERATING INCOME (LOSS)		$48,337	$48,874
F.	Capital Expenditures		
1.	Retirement of Principal		
2.	Interest		
	Total Capital Expenditures	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$48,337	$48,874

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	**Year 2016**	**Year 2017**
1. Purchased Services	$34,840	$35,181
2. Professional Fees	$10,237	$10,075
3. Miscellaneous	$120,042	$119,913
4.		
5.		
6.		
7.		
Total Other Expenses	**$165,119**	**$165,169**

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

RESPONSE: Midtown Hospital presents the current and projected charges for an total joint replacement surgery case in **Exhibit 12**. An annual increase of 5% between FY2013 and Year 1 of the project, FY2016, is projected. Afterwards, the hospital assumes that charges will increase by 5% annually. Despite the modest charge increase, Midtown Hospital expects that contractual and other adjustments will increase, which will result in lower net revenue per case. Midtown Hospital's project will improve operational efficiency and the overall level of total joint replacement surgery care that it provides while maintaining a charge structure that is reasonable and reflects the complexity of its cases and the overall market for total joint replacement surgery. As demonstrated in **Exhibit 13**, Midtown Hospital's total joint replacement surgery charges compare favorably with other providers in Nashville.

EXHIBIT 12
MIDTOWN HOSPITAL TOTAL JOINT REPLACEMENT SURGERY
AVERAGE GROSS CHARGE PER CASE, CURRENT AND PROJECTED

	Current	FY2016	FY2017
Gross Charge	$54,622	$62,563	$65,691
Adjustment	$34,018	$43,541	$46,669
Net Revenue	$20,604	$19,022	$19,022

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

RESPONSE: Comparison charge data for total joint replacement surgery is very limited. To compare its total joint replacement surgery charges with similar facilities, Midtown Hospital used Medicare data from the American Hospital Directory (AHD) or ahd.com, as a source. Midtown Hospital profiled eight Nashville hospitals from the AHD database. The number of Medicare orthopedic surgery inpatients ranged from a low of 18 patients for Nashville General Hospital at Meharry to a high of 1,472 patients for Saint Thomas Hospital. Because of the very low volume of orthopedic surgery patients reported by Nashville General Hospital at Meharry, Midtown Hospital excluded it from the comparison.

Excluding low volume providers and specialty hospitals, the remaining six hospitals averaged 799 orthopedic surgery inpatients and charged, on average, $68,503 per inpatient case. Average charges per case ranged from a low of $51,117 for TriStar Southern Hills Medical Center to a high of $92,828 for TriStar Skyline Medical Center. Midtown Hospital's average charge was $62,027, approximately 10% less than the average for the seven hospitals. Three of the hospitals had charges higher than Midtown Hospital (TriStar Centennial, TriStar Skyline Medical Center and Vanderbilt University Medical Center) and two of the hospitals had charges lower than Midtown Hospital (Saint Thomas Hospital and TriStar Southern Hills Medical Center).

Adjusting the average charge by the orthopedic surgery Medicare Case Mix Index (CMI) resulted in a range of "CMI adjusted" charges of $20,252 to $31,348 with an average CMI adjusted charge of $25,168. Midtown Hospital's CMI adjusted charge was $22,694, again, approximately 10% less than the average for the six hospitals. Please see **Exhibit 13**, which profiles the orthopedic surgery average charge data for the Nashville hospitals.

EXHIBIT 13
NASHVILLE AREA HOSPITALS
AVERAGE GROSS CHARGE PER MEDICARE ORTHOPEDIC SURGERY CASE

Hospital	Inpatients	Avg Charges	CMI	CMI Adj Charge
Baptist Hospital	903	$62,027	2.7332	$22,694
Saint Thomas Hospital	1,472	$52,512	2.4128	$21,764
TriStar Centennial	1,030	$76,897	3.1111	$24,717
TriStar Skyline Medical Center	331	$92,828	2.9612	$31,348
TriStar Southern Hills Medical Center	131	$51,117	2.5241	$20,252
Vanderbilt University Medical Center	926	$75,637	2.5020	$30,231
Average	**799**	**$68,503**	**2.7074**	**$25,168**

Source: American Hospital Directory, ahd.com

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

RESPONSE: Midtown Hospital's orthopedic surgery service line is already financially feasible. This proposal will enhance the current service line by consolidating and expanding its operating rooms into an total joint replacement surgery suite. The proposed project will improve operational efficiency including patient flow and staff productivity by operating the total joint replacement service line in one location and providing a single floor experience for the patient. In addition, expanding the size of the operating rooms will allow Midtown Hospital to providing imaging equipment and larger operating tables in the operating rooms, which will allow its physicians to perform more cases that are complex. Midtown Hospital and area payors will benefit from an increase in projected utilization rates and cost-effectiveness. As indicated in the Projected Data Chart, projected utilization will be sufficient to continue to allow Midtown Hospital to operate efficiently and effectively.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

RESPONSE: As indicated in the Projected Data Chart, projected cash flow will ensure financial viability within two years and over the long-term.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

RESPONSE: Midtown Hospital currently participates in both the Medicare and TennCare/Medicaid programs and has a history of providing care regardless of payor source. Using 2012 Joint Annual Report data, Midtown Hospital had an estimated payor mix (based on gross charges) that was 37.9% Medicare, 12.5% Medicaid/TennCare and 4.8% self pay. Additionally, based on the 2012 JAR, Midtown provided $53,215,189 in care to charity/medically indigent patients (accounting for 13.7% of net patient charges of $389,421,191). During the first year of operation, Midtown Hospital's payor mix is anticipated to be 37.9% Medicare and 14.0% Medicaid/TennCare. This amounts to approximately $626,085,630 in Medicare gross charges in Year 1 and $231,271,740 Medicaid/TennCare gross charges in Year 1. In addition, Midtown Hospital proposes to provide $38,611,000 in charity care in Year 1.

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

RESPONSE: Please see **Attachment C, Economic Feasibility – 10 (Tabs 14 and 15)**.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

RESPONSE: Saint Thomas Health seeks approval to develop a center of excellence for total joint replacement services. This project will improve operational efficiency across the health system, provide ORs that are large enough to accommodate imaging equipment and larger operating tables and enhance the overall quality of total joint replacement surgery services. Achieving these objectives was instrumental in the decision to proceed with this project at Midtown Hospital.

Although studied, Saint Thomas Health did not consider renovating and enlarging the existing operating rooms at West Hospital to be a more viable option. Although major construction is now taking place at West Hospital, the total joint replacement services project would further disrupt services at West Hospital and leave excess square footage at Midtown Hospital.

New construction of the total joint replacement services project at Midtown Hospital was also considered. However, this current project was considered to be the superior plan. Midtown Hospital anticipated the cost of new construction at Midtown Hospital to be higher than the costs of the proposed project. In addition, new construction would not necessarily allow the total joint replacement surgery suite to be contiguous to an inpatient unit. This option allows Midtown Hospital to create a single floor experience for its total joint replacement patients and gain the advantage of improved staff communication and care coordination that comes from the surgical suite and inpatient unit being on the same floor and contiguous.

Midtown Hospital's proposal to renovate the eighth floor to accommodate consolidated total joint replacement services from two hospital campuses is the most responsible plan for addressing the current facility limitations. The project addresses all of the deficiencies of both Midtown Hospital's and West Hospital's existing total joint replacement operating rooms and does so in a cost-effective approach.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

RESPONSE: Not applicable. This project does not involve any new construction.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

RESPONSE: As a member of Saint Thomas Health, Midtown Hospital is a member of an integrated healthcare system of four hospitals. Additionally, Midtown Hospital has many active relationship and several formal agreements in place to provide for seamless care of its patients, including:

Managed Care Contracts

- Aetna / US Healthcare
- Aetna Institutes of Quality Bariatric Surgery Facility
- Aetna Institutes of Quality Orthopedic Care
- Alive Hospice
- UnitedHealthcare Community Plan (f/k/a Americhoice)
- AMERIGROUP Community Care
- Avalon Hospice
- Beech
- BC/BS of TN
- CCN
- Blue Distinction Center for Bariatric Surgery
- Blue Distinction Center for Knee and Hip Replacement
- Blue Distinction Center for Spine Surgery
- Bluegrass Family Health
- CenterCare Managed Care Programs
- Cigna Healthplan
- CorVel Corporation
- Coventry Health Care
- Division of Rehabilitation Services
- First Health
- FOCUS Healthcare Management
- Great West
- HealthMarkets Care Assured
- Health Payors Organization, Ltd. / Interplan Healthgroup
- HealthSpring
- Humana Health Care Plans
- KY Medicaid
- MultiPlan
- NovaNet
- OccuComp
- Odyssey Healthcare
- Prime Health
- Private Healthcare Systems, Ltd.
- Pyramid Life - Today's Options
- Signature Health Alliance
- Southern Benefit Administrators, Inc.
- Starbridge Choice
- Sterling Healthcare

- TriCare for Life
- TRICARE North
- TRICARE South
- United Healthcare
- UnitedHealthcare Community Plan (f/k/a Americhoice)
- USA Managed Care Organization
- Windsor HealthCare

Transfer Agreements

- American Endoscopy Center, P.C.
- Baptist Plaza Surgicare, LP (USPI)
- Baptist Women's Health Center, LLC d/b/a The Center for Spinal Surgery (USPI)
- Biomat USA, Inc.
- Blakeford at Green Hills d/b/a Woodcrest Healthcare Center
- Clarksville Health System, G.P.
- Cool Springs Surgery Center
- Crockett Hospital, LLC
- Cumberland Medical Center, Inc.
- Decatur County General Hospital
- Decatur County General Hospital
- Digestive Disease Endoscopy Center, Inc
- Emergency Patient Transfer - Mutual Agreement for Emergency Patient Transfer
- Eye Surgery Center of Nashville
- Hardin Medical Center
- Joseph B. Delozier, III, PLLC - Baptist
- Lincoln Medical Center
- Lincoln Medical Center - Baptist
- Livingston Regional Hospital, LLC
- Maxwell Aesthetics, PLLC - Baptist
- Nashville Vision Correction - Baptist
- Office of Emergency Management
- Oral Facial Surgery Center, Inc.
- Pinelake Regional Hospital, LLC d/b/a Jackson Purchase Medical Center
- Renal Care Group, Inc
- Saint Thomas Hospital
- Southern Tennessee Medical Center
- Specialty MRI (Radiology Alliance)
- Tullahoma HMA, LLC d/b/a Harton Regional Medical Center
- Urology Surgery Center, L.P.
- Vanderbilt University
- Vanderbilt University - Burn Patient
- Vanderbilt University - Organ Transplant and Intensive Care Pediatrics
- Wellmont Bristol Regional Medical Center

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

RESPONSE: Midtown Hospital's proposal will have a positive impact on the health care system. Midtown Hospital is not proposing any new services or CON reviewable equipment. This project is

to build a center of excellence for total joint replacement services on the Midtown Hospital campus that includes developing a new operating suite for joint replacement surgeries. When the project is completed, Midtown Hospital will have ten dedicated operating rooms appropriately sized and equipped for the needs of joint replacement procedures. This will allow for coordination and consolidation of joint replacement programs across Saint Thomas Health's two Nashville campuses – Midtown and West – resulting in greater efficiency and operation. This ten operating room project also remains operating room neutral in the market while capitalizing on the strengths of two award-winning total joint replacement programs.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

RESPONSE: **EXHIBIT 14** illustrates current (Midtown Hospital only) and proposed staffing levels for the proposed project. Midtown Hospital will add approximately 44.7 FTEs through a combination of relocating existing staff from West Hospital and recruiting additional staff from the community. In anticipation of the realignment and consolidation of total joint replacement services, Midtown Hospital has budgeted approximately 35 "additional" FTEs from West Hospital via relocation of existing staff there and 9.7 "new" FTEs from the community via additional recruiting for the proposed project.

EXHIBIT 14
CURRENT AND PROPOSED STAFFING LEVELS
TOTAL JOINT REPLACEMENT SERVICES
(FULL TIME EQUIVALENTS)

Position	Current	Proposed	Difference
Administrative	3.0	4.0	1.0
Registered Nurses - Holding Room	2.0	3.5	1.5
Registered Nurses - OR	6.4	11.2	4.8
Surgical Technicians	9.6	16.8	7.2
Registered Nurses - PACU	3.0	5.3	2.3
Registered Nurses - Nursing Unit	7.4	21.1	13.7
Patient Care Techs - Nursing Unit	4.5	12.7	8.2
Orthopedic Nurse Practitioners	0.0	2.0	2.0
Orthopedic Case Managers	1.0	4.0	3.0
Research Professionals	0.0	1.0	1.0
TOTAL	**36.9**	**81.6**	**44.7**

Midtown Hospital has a history of successfully retaining professional and administrative staff because it provides competitive benefits and compensation, and provides a supportive work environment. As mentioned previously, in recent years, Midtown Hospital was named in Modern Healthcare's Best Places to Work in Healthcare and received the Tennessee Nurses Association's Outstanding Employer Award.

EXHIBIT 15 profiles comparable positions and salaries for the Nashville-Davidson-Murfreesboro MSA. Midtown Hospital's salaries and wages are competitive with the market. The proposed

project's average proposed annual salary for registered nurses is $68,081 while the average salary for surgical technicians is $58,205. These midpoint values very competitive compared to the Nashville-Davidson-Murfreesboro MSA.

EXHIBIT 15
NASHVILLE-DAVIDSON-MURFREESBORO MSA
MAY 2012 ANNUAL WAGE RATES

Position	25th Pctile	Mean	Median	75th Pctile
Registered Nurses	$48,220	$58,260	$58,060	$68,600
Surgical Technicians	$34,290	$42,090	$39,970	$49,100

SOURCE: ANNUAL SALARY BLS OCCUPATIONAL EMPLOYMENT STATISTICS SURVEY DATA

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

RESPONSE: Midtown Hospital proposes adding just 9.7 "new" FTEs from the community. Midtown Hospital has a history of successfully recruiting professional and administrative staff. It provides competitive benefits and compensation, and is committed to the retention of existing personnel. In recent years, Midtown Hospital was named in Modern Healthcare's Best Places to Work in Healthcare and received the Tennessee Nurses Association's Outstanding Employer Award.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

RESPONSE: Midtown Hospital has reviewed and understands the licensure and certification requirements for medical and clinical staff. As an existing licensed and Joint Commission-accredited facility, Midtown Hospital has administrative policies and procedures in place to ensure that licensure and certification requirements are followed. Furthermore, Midtown Hospital maintains quality standards that are focused on continual improvement. Please see **Attachment C, Contribution to the Orderly Development of Health Care – 5** for copies of its Quality and Patient Safety Improvement Plan **(Tab 17)**, and Utilization Review Plan **(Tab 18)** and Patient Bill of Rights **(Tab 19)**.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.,* internships, residencies, etc.).

RESPONSE: Midtown Hospital participates in many regional healthcare teaching and training programs including:

- Aquinas College - Nursing Program
- Aquinas College - RN-BSN Program
- Auburn University – Nursing
- Austin Peay State University - Exercise Science Students
- Austin Peay State University - Medical Technology
- Austin Peay State University – Nursing
- Belmont University - Nursing Program
- Belmont University – Pharmacy

- Belmont University - Physical and Occupational Therapy (PT, OT)
- Central Michigan University - Exercise Science Program
- Chattanooga State Technical Community College - Diagnostic Medical Sonography, Radiation Therapy and Nuclear Medicine
- Columbia State Community College - Respiratory Care, EMS Education & Nursing
- Creighton University – Nursing
- Cumberland University - Nursing Program
- Draughons Junior College - Physical Therapy, Assistant Cardiographic and Medical Assistant
- Draughons Junior College, Inc d/b/a Daymar Institute - Pharmacy Technology
- Dyersburg State Community College - Health Information Technology
- Hospital Authority of Metropolitan Government of Nashville & Davidson County d/b/a Nashville General Hospital - Radiologic Technology
- Johns Hopkins University School of Nursing
- Lipscomb University - Dietetic Internship Program
- Lipscomb University - Exercise Science
- Lipscomb University College of Pharmacy - Pharmacy Students
- Lipscomb University Department of Nursing
- Madisonville Community College - Medical Equipment and Instrumentation Students
- Medvance Institute - Medical Laboratory Technician
- Medvance Institute - Surgical Technology and Sterile Technology Programs
- Middle Tennessee State University (MTSU) - Exercise Science
- Middle Tennessee State University (MTSU) - Medical Nutrition Therapy Dietetic Practicum
- Middle Tennessee State University (MTSU) - Nursing program
- Middle Tennessee State University (MTSU) - Social Work
- Miller-Motte Technical College - Respiratory Therapy, Surgical Technology and Sterile Processing
- Motlow State Community College – Nursing
- Mountain State University - Radiology Students
- Murray State University – Nursing
- Nashville State Community College - Nursing - Surgical Technician Program - Surgical Assist Program
- Nashville State Technical Community College - Occupational Therapy Program
- Pennsylvania State University - Nursing Program
- Samford University - Nursing (Graduate Nursing Clinical Experience Management, Nurse Executive and Nurse Educator Students)
- South Carolina College of Pharmacy - Doctor of Pharmacy
- Southeastern Institute - Paramedic Students
- Southern Adventist University – Nursing
- St. Louis University, School of Nursing
- Tennessee Board of Regents (TBR) - Master of Science in Nursing Regents Online Degree Program (APSU, ETSU, MTSU, TSU, TTU, and Memphis)
- Tennessee State University (TSU) - Health Exercise Science (Baptist Sports Medicine)
- Tennessee State University (TSU) – Nursing
- Tennessee State University (TSU) - Physical, Occupational Therapy, Health Information Management and Cardio-Respiratory Care
- Tennessee Technological University - Nursing and Dietetics Program
- Tennessee Technology Center at Murfreesboro - Pharmacy Technician, Phlebotomy, and Surgical Tech
- Tennessee Technology Center at Nashville - LPN, Phlebotomy & Pharmacy Tech
- Tennessee Technology Center at Shelbyville and Murfreesboro Campuses - Practical Nursing Program
- Trevecca Nazarene University - Social Work Students

- University of Alabama, Huntsville – Nursing
- University of Alabama, Tuscaloosa – Nursing
- University of Florida - Pham. D. Program
- University of St. Francis - Nursing Students
- University of Tennessee (Memphis) - Physical Therapy, Occupational Therapy, Medical Technology, Cytotechnology and Histotechnology
- University of Tennessee at Chattanooga - Physical Therapy
- University of Tennessee at Martin - Clinical Nutrition and Food Service Management
- University of Tennessee, Knoxville – Nursing
- University of Tennessee, Knoxville - Social Work
- University of Tennessee, Martin - Exercise Science
- University of Tennessee, Memphis - Pharmacy Program
- Vanderbilt School of Nursing – Nursing
- Vanderbilt University - Hearing and Speech Sciences
- Volunteer State Community College - Multi-Programs
- Walden University - MS Nursing Students)
- Western Kentucky University - Nursing Program

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

RESPONSE: As an existing hospital, Midtown Hospital is licensed by the Tennessee Department of Health. Midtown Hospital has reviewed and understands the licensure requirements.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: Board of Licensing Health Care Facilities, State of Tennessee, Department of Health.

Accreditation: Midtown Hospital is accredited by The Joint Commission (on Accreditation of Healthcare Organizations). Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(b) (Tab 20)** for the most recent report.

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

RESPONSE: Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(c) (Tab 21).** The current license is valid until April 30, 2014.

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

RESPONSE: Please see **Attachment C, Contribution to the Orderly Development of Health Care – 7.(d)** for a copy of the most recent licensure/certification inspection report **(Tab 22)** and plan of corrective action **(Tab 23)**.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

RESPONSE: There have been no final orders or judgments placed against Midtown Hospital or any entity or person with more than 5 percent ownership.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

RESPONSE: There have been no civil or criminal judgments against Midtown Hospital or any entity or person with more than 5 percent ownership.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number, and type of procedures performed, and other data as required.

RESPONSE: Yes, Midtown Hospital will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number, and type of procedures performed, and other data as required. Additionally, Midtown Hospital submits a Joint Annual Report (JAR) to the Department of Health and will continue to do so.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Please see **Attachment D – Proof of Publication (Tabs 24-25).**

DEVELOPMENT SCHEDULE

Tennessee Code Annotated §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

2. **If the response to the preceding question indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph, please state below any request for an extended schedule and document the "good cause" for such an extension.**

   RESPONSE: The project completion schedule below reflects the anticipated schedule for the operating room project.

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

PROJECT FORECAST COMPLETION CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(April, 2014

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	0	Jan-14
2. Construction documents approved by the Tennessee Department of Health**	196	Aug-14
3. Construction contract signed	167	Jun-14
4. Building permit secured	196	Aug-14
5. Site preparation completed	N/A	
6. Building construction commenced	196	Aug-14
7. Construction 40% complete	400	Feb-15
8. Construction 80% complete	525	Jun-15
9. Construction 100% complete (approved for occupancy)	592	Aug-15
10. *Issuance of license	612	Sep-15
11. *Initiation of service	612	Sep-15
12. Final Architectural Certification of Payment	642	Oct-15
13. Final Project Report Form (HF0055)	642	Oct-15

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

**** Early release date; final document approval Nov-14**

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Davidson

Barbara Houchin being first duly sworn, says that he/she is the applicant named in this application or his/her lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Barbara Houchin / Executive Director
SIGNATURE/TITLE

Sworn to and subscribed before me this 13th day of January (Month), 2014 (Year) a Notary

Public in and for the County/State of Davidson County, Tennessee

Sonja Rene' Ward
NOTARY PUBLIC

My commission expires March 8 (Month/Day), 2016 (Year).

JAN 15 '14 PM 12:46

THIS DOCUMENT CONTAINS SECURITY FEATURES -- SEE BACK FOR DETAILS

Ascension Health Ministry SVC CTR
4040 Vincennes Circle
Indianapolis, IN 46268
317-334-VEND (8363)

The Bank of New York Mellon
Pittsburgh, Pennsylvania

518458

60-160
433

VOID VOID

Date Jan/10/2014 Pay Amount $45,000.00***

Pay ****FORTY-FIVE THOUSAND AND XX / 100 DOLLAR****

To The Order Of
TN HEALTH SVCS
500 DEADERICK ST
OFC BL
NASHVILLE, TN 37242

VOID VOID V

Authorized Signature

VOID AFTER 90 DAYS

Authorized Signature

VOID VOID

TABLE OF CONTENTS

Attachment A

Corporate Charter
Organizational Chart
Board Roster
Certificate of Corporate Existence
Deed
MCO/BHO Participation

Tab 1

Attachment A, 3

Corporate Charter

JUL 15 '13 PM 12:55

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Saint Thomas Midtown Hospital
ATTN: CONTRACT ADMINSTRATION
STE 800
102 WOODMONT BLVD
NASHVILLE, TN 37205-2221

July 10, 2013

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Control # : 414306 Status: Active
Filing Type: Corporation Non-Profit - Domestic

Document Receipt

Receipt # : 1089206	Filing Fee:	$20.00
Payment-Check/MO - BRADLEY ARANT BOULT CUMMINGS LLP, Nashville, TN		$20.00

Amendment Type: Articles of Amendment Image # : 7221-1974
Filed Date: 07/10/2013 11:26 AM

This will acknowledge the filing of the attached articles of amendment with an effective date as indicated above. When corresponding with this office or submitting documents for filing, please refer to the control number given above.

You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee.

Tre Hargett
Secretary of State

Processed By: Cheryl Donnell

Field Name	Changed From	Changed To
Filing Name	SETON CORPORATION	Saint Thomas Midtown Hospital

ARTICLES OF AMENDMENT

OF

SETON CORPORATION

CONTROL NO. 0414306

FILED

To the Tennessee Secretary of State:

Pursuant to Section 48-60-105 of the Tennessee Nonprofit Corporation Act, as amended, the undersigned officer of Seton Corporation, a domestic nonprofit corporation (the "Corporation"), hereby submits these Articles of Amendment to its Charter on July 10, 2013:

(1) The name of the Corporation as it appears of record is Seton Corporation.

(2) The Corporation is not for profit.

(3) The text of the Amendment is as follows: Article I, Section 1.1 of the Amended and Restated Charter of the Corporation is deleted and the following language shall be substituted in its place:

1.1 The name of the corporation is "Saint Thomas Midtown Hospital"

(4) The Articles of Amendment were duly adopted by the sole member of the Corporation on June 27, 2013.

(5) Approval of the amendment to the charter by some person or persons other than the sole member of the Corporation, the Board of Trustees, or the incorporator, is not required pursuant to Section 48-60-301 of the Tennessee Nonprofit Corporation Act, as amended.

(6) The Articles of Amendment shall be effective on the date of filing.

SETON CORPORATION

By: _____

Bernard J. Sherry, President/CEO

7/3156641.1

Box 37
LFinley

Secretary of State
Division of Business Services
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, Tennessee 37243

DATE: 01/03/02
REQUEST NUMBER: 4378-2087
TELEPHONE CONTACT: (615) 741-2286
FILE DATE/TIME: 12/31/01 1516
EFFECTIVE DATE/TIME: 12/31/01 1630
CONTROL NUMBER: 0414306

TO:
BOULT CUMMINGS CONNERS & BERRY PLC
PO BOX 198062

NASHVILLE, TN 37219

Davidson County CHARTER
Recvd: 01/07/02 15:15 7pgs
Fees:8.00 Taxes:0.00
20020107-0002449

RE:
SETON CORPORATION
AMENDED AND RESTATED CHARTER

THIS WILL ACKNOWLEDGE THE FILING OF THE ATTACHED DOCUMENT WITH AN EFFECTIVE DATE AS INDICATED ABOVE.

WHEN CORRESPONDING WITH THIS OFFICE OR SUBMITTING DOCUMENTS FOR FILING, PLEASE REFER TO THE CORPORATION CONTROL NUMBER GIVEN ABOVE.

PLEASE BE ADVISED THAT THIS DOCUMENT MUST ALSO BE FILED IN THE OFFICE OF THE REGISTER OF DEEDS IN THE COUNTY WHEREIN A CORPORATION HAS ITS PRINCIPAL OFFICE IF SUCH PRINCIPAL OFFICE IS IN TENNESSEE.

FOR: AMENDED AND RESTATED CHARTER ON DATE: 01/03/02

	FEES	
RECEIVED:	$40.00	$0.00
TOTAL PAYMENT RECEIVED:		$40.00

FROM:
BOULT, CUMMINGS, CONNERS & BERRY
P. O. BOX 198062

NASHVILLE, TN 37219-0000

RECEIPT NUMBER: 00002977184
ACCOUNT NUMBER: 00000413

Riley C Darnell

RILEY C. DARNELL
SECRETARY OF STATE

000064

SS-4458

4378 2097

FILED

CERTIFICATE OF SETON CORPORATION CONCERNING ITS AMENDED AND RESTATED CHARTER

RECEIVED
STATE OF TENNESSEE
01 DEC 31 PM 3:16
RILEY DARNELL
SECRETARY OF STATE

Corporate Control No. 0414306

Pursuant to the provisions of Section 48-60-106(h) of the Tennessee Nonprofit Corporation Act, as amended, Seton Corporation (the "Corporation") certifies as follows:

I. The name of the Corporation as it appears of record is Seton Corporation.

II. The Amended and Restated Charter to which this Certificate is attached amends Articles I through VIII of the Corporation's Charter by substituting therefor Articles I through VIII of the Amended and Restated Charter.

III. The Amended and Restated Charter was duly adopted by unanimous written consent of the Board of Trustees of the Corporation dated as of December 31, 2001 and approved by action of the Chief Executive Officer of Saint Thomas Health Services, a Tennessee nonprofit corporation and the sole member of the Corporation ("STHS").

IV. The Corporation is not for profit.

V. Approval of the amendments to the Charter by some person or persons other than the Board of Trustees and the Chief Executive Officer of STHS is not required pursuant to Section 48-60-301 of the Tennessee Nonprofit Corporation Act, as amended.

VI. The Amended and Restated Charter shall be effective on the date of filing.

DATED as of the 31st day of December, 2001.

SETON CORPORATION

By: Thomas E. Beeman
Thomas E. Beeman
Chairman, Board of Trustees

AMENDED AND RESTATED CHARTER OF SETON CORPORATION

Pursuant to the provisions of Section 48-60-106 of the Tennessee Nonprofit Corporation Act, as amended (the "Act"), Seton Corporation, a Tennessee nonprofit corporation (the "Corporation") adopts the following Amended and Restated Charter:

ARTICLE I
NAME

1.1 The name of the Corporation is Seton Corporation.

ARTICLE II
TYPE

2.1 The Corporation is a public benefit corporation.

2.2 The Corporation is not for profit.

ARTICLE III
PURPOSE

3.1 The Corporation is organized exclusively for charitable, religious, educational and scientific purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law) (the "Code"), including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Code. The Corporation's purposes shall be consistent with and supportive of the corporate purposes of Ascension Health, a Missouri nonprofit corporation, and the Corporation's purposes shall include the following:

3.1.1 Serve as an integral part of the Roman Catholic Church and carry out its mission in support of or in furtherance of the charitable purposes of the organizations described in this Article.

3.1.2 Further the philosophy and mission of Ascension Health of healing and service for the sick and poor, and promote, support and engage in any of the religious, charitable, scientific and educational ministries which are now, or may hereafter be established by Ascension Health, or co-sponsored by the Sponsors (as that term is generally understood within the Ascension Health system) and which are in furtherance of or in support of the charitable purposes of the organizations described in this Article.

3.1.3 Raise funds for any or all of the organizations described in this Article from the public and from all other sources available; receive and maintain such

funds and expend principal and income therefrom in support of or in furtherance of the charitable purposes of such organizations.

3.1.4 Acquire, own, use, lease as lessor or lessee, convey and otherwise deal in and with real and personal property and any interest therein, all in support of or in furtherance of the charitable purposes of organizations described in this Article.

3.1.5 Contract with other organizations (for profit and nonprofit), with individuals and with governmental agencies in support of or in furtherance of the charitable purposes of the organizations described in this Article.

3.1.6 Establish, develop, sponsor, promote and/or conduct educational programs, religious programs, scientific research, treatment facilities, rehabilitation centers, housing centers, management services, human service programs and other charitable activities, all in promotion and support of the interests and purposes of the organizations described in this Article.

3.1.7 Own or operate facilities or own other assets for public use and welfare in furtherance of the charitable purposes of the organizations described in this Article.

3.1.8 Engage in any lawful activities within the purposes for which a corporation may be organized under the Tennessee Nonprofit Corporation Act (the "Act"), as it may be amended from time to time, which are in furtherance of or in support of the charitable purposes of the organizations described in this Article.

3.1.9 Serve as the controlling entity of Subsidiary Organizations (as that term is generally understood within the Ascension Health system) that conduct health related and other activities, and limit the powers, duties and responsibilities of the governing bodies of such Subsidiary Organizations, all in accordance with requirements as established by the Corporate Member (as defined in Article V).

3.1.10 Support institutions co-sponsored by the Sponsors, both within and without Tennessee, and cooperate with other Ascension Health institutions.

3.1.11 Promote cooperation and exchange of knowledge and experience among the various apostolates of the Sponsors within the health care mission.

3.1.12 Otherwise operate in support of or in furtherance of the charitable purposes of the organizations described in this Article, and do so exclusively for religious, charitable, scientific or educational purposes within the meaning of Section 501(c)(3) of the Code and in the course of such operation:

(a) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its members, trustees, officers, or other private persons unless allowed by Section 501(c)(3) of the Code and the Act except that the Corporation shall be authorized and empowered to pay

reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.

(b) No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office.

(c) Notwithstanding any other provisions of the Corporation's governing documents, the Corporation shall not carry on any other activities not permitted to be carried on: (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

3.1.13 Operate a hospital and other health care providers and services in furtherance of the charitable purposes described above.

ARTICLE IV
PERIOD OF EXISTENCE

4.1 The period during which the Corporation shall continue is perpetual.

ARTICLE V
MEMBERSHIP

5.1 Members. The Corporation shall have members.

5.2 Identity of Member. There shall be one (1) member of the Corporation who shall be known as the "Corporate Member," and such Corporate Member shall be St. Thomas Baptist Health Corporation, a Tennessee nonprofit corporation.

5.3 Transferability of Membership Interest. The Corporate Member's interest as a member in the Corporation may be transferred by the Corporate Member.

ARTICLE VI
REGISTERED OFFICE, AGENT, PRINCIPAL OFFICE, AND INCORPORATOR

6.1 Registered Office and Agent. The street address, zip code and county of the registered office of the Corporation is 4220 Harding Road, Nashville, Davidson County, Tennessee 37205, and the name of the Corporation's registered agent at such address is Sister Priscilla Grimes, D.C.

6.2 Principal Office. The address of the principal office of the Corporation is 2000 Church Street, Nashville, Davidson County, Tennessee 37236.

6.3 Incorporator. The name and address of the Corporation's incorporator is J. B. Hardcastle, Jr., 414 Union Street, Suite 1600, Nashville, Davidson County, Tennessee 37219.

ARTICLE VII
BOARD OF TRUSTEES; RESERVED POWERS

7.1 Powers and Responsibilities. The business, property, and affairs of the Corporation shall be managed and controlled by the Corporation's Board of Trustees ("Board of Trustees" or "Board") in accordance with the policies established by the Corporate Member or any successor entity. The Board of Trustees shall act as the board of directors of the Corporation as required by the Act.

7.2 Powers Reserved to Corporate Member. All action of the Corporation shall be by its Board of Trustees, subject to the following matters which require the approval of the Corporate Member:

7.2.1 Approve the mission and vision statements for the Corporation and assure compliance with the philosophy, mission, vision, Sponsor expectations and core values of the System.

7.2.2 Approve changes to the Governing Documents (as that term is generally understood within the Ascension Health system) of the Corporation and its non-controlled subsidiaries that are consistent with the System's Requirements for Governing Documents (as that term is generally understood within the Ascension Health system).

7.2.3 Approve changes to the Governing Documents of the Corporation and its non-controlled subsidiaries that are inconsistent with the System's Requirements for Governing Documents, provided that Ascension Health also approves such changes.

7.2.4 Appoint, upon the recommendation of the Board of the Corporation, or remove, with or without cause, the members of the Board of Trustees of the Corporation. Removal does not require a recommendation of the Corporation's Board.

7.2.5 Approve the incurrence of debt of the Corporation in accordance with the System Authority Matrix (as that term is generally understood within the Ascension Health system).

7.2.6 Subject to canonical requirements, approve and recommend the formation of legal entities, the sale, transfer or substantial change in use of all or substantially all of the assets, divestitures, dissolutions, closures, mergers, consolidations, or changes in corporate membership of the Corporation in accordance with the System Authority Matrix.

7.2.7 Approve the transfer or encumbrance of the assets of the Corporation in accordance with the System Authority Matrix.

7.2.8 Approve the operating budget and capital plan for the Corporation.

7.2.9 Deviate from the polices and restrictions imposed on the Corporation by the Corporate Member.

ARTICLE VIII
DISSOLUTION

8.1 Upon the dissolution of the Corporation, the disposition of all the assets of the Corporation shall be in a manner as provided by the Board of Trustees (subject to the prior approval of the Corporate Member) and in accordance with the following:

8.1.1 The paying of or the making of provision of the payment of all of the liabilities, direct or indirect, contingent or otherwise, including without limitation, all liabilities evidenced in all outstanding loan agreements, credit agreements, master indentures and other similar documents.

8.1.2 Subject to compliance with the dissolution principles of the Corporate Member, all assets remaining after the payment of all of the liabilities of the Corporation shall be distributed, exclusively in furtherance of the religious, charitable, scientific, literary and educational purposes of the Corporation within the meaning of Section 501(c)(3) of the Code, to St. Thomas Baptist Health Corporation or such other exempt organization(s) under Section 501(c)(3) of the Code that is a Subsidiary Organization of St. Thomas Baptist Health Corporation, or to such other exempt organization(s) under Section 501(c)(3) of the Code as shall be determined by the Members of Ascension Health.

8.1.3 Any other assets not so disposed of shall be distributed for one or more exempt purposes within the meaning of Section 501(c)(3) of the Code, or shall be distributed to the federal government, or to a state or local government, for a public purpose. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction of the county in which the principal office of the Corporation is then located, exclusively for such purposes or to such organization or organizations, as said Court shall determine, which are organized and operated exclusively for such purposes.

This Amended and Restated Charter shall be effective on December 31, 2001.

AMENDED AND RESTATED CHARTER OF SETON CORPORATION

Pursuant to the provisions of Section 48-60-106 of the Tennessee Nonprofit Corporation Act, as amended (the "Act"), Seton Corporation, a Tennessee nonprofit corporation (the "Corporation") adopts the following Amended and Restated Charter:

ARTICLE I
NAME

1.1 The name of the Corporation is Seton Corporation.

ARTICLE II
TYPE

2.1 The Corporation is a public benefit corporation.

2.2 The Corporation is not for profit.

ARTICLE III
PURPOSE

3.1 The Corporation is organized exclusively for charitable, religious, educational and scientific purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law) (the "Code"), including, for such purposes, the making of distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Code. The Corporation's purposes shall be consistent with and supportive of the corporate purposes of Ascension Health, a Missouri nonprofit corporation, and the Corporation's purposes shall include the following:

3.1.1 Serve as an integral part of the Roman Catholic Church and carry out its mission in support of or in furtherance of the charitable purposes of the organizations described in this Article.

3.1.2 Further the philosophy and mission of Ascension Health of healing and service for the sick and poor, and promote, support and engage in any of the religious, charitable, scientific and educational ministries which are now, or may hereafter be established by Ascension Health, or co-sponsored by the Sponsors (as that term is generally understood within the Ascension Health system) and which are in furtherance of or in support of the charitable purposes of the organizations described in this Article.

3.1.3 Raise funds for any or all of the organizations described in this Article from the public and from all other sources available; receive and maintain such

funds and expend principal and income therefrom in support of or in furtherance of the charitable purposes of such organizations.

3.1.4 Acquire, own, use, lease as lessor or lessee, convey and otherwise deal in and with real and personal property and any interest therein, all in support of or in furtherance of the charitable purposes of organizations described in this Article.

3.1.5 Contract with other organizations (for profit and nonprofit), with individuals and with governmental agencies in support of or in furtherance of the charitable purposes of the organizations described in this Article.

3.1.6 Establish, develop, sponsor, promote and/or conduct educational programs, religious programs, scientific research, treatment facilities, rehabilitation centers, housing centers, management services, human service programs and other charitable activities, all in promotion and support of the interests and purposes of the organizations described in this Article.

3.1.7 Own or operate facilities or own other assets for public use and welfare in furtherance of the charitable purposes of the organizations described in this Article.

3.1.8 Engage in any lawful activities within the purposes for which a corporation may be organized under the Tennessee Nonprofit Corporation Act (the "Act"), as it may be amended from time to time, which are in furtherance of or in support of the charitable purposes of the organizations described in this Article.

3.1.9 Serve as the controlling entity of Subsidiary Organizations (as that term is generally understood within the Ascension Health system) that conduct health related and other activities, and limit the powers, duties and responsibilities of the governing bodies of such Subsidiary Organizations, all in accordance with requirements as established by the Corporate Member (as defined in Article V).

3.1.10 Support institutions co-sponsored by the Sponsors, both within and without Tennessee, and cooperate with other Ascension Health institutions.

3.1.11 Promote cooperation and exchange of knowledge and experience among the various apostolates of the Sponsors within the health care mission.

3.1.12 Otherwise operate in support of or in furtherance of the charitable purposes of the organizations described in this Article, and do so exclusively for religious, charitable, scientific or educational purposes within the meaning of Section 501(c)(3) of the Code and in the course of such operation:

(a) No part of the net earnings of the Corporation shall inure to the benefit of, or be distributable to, its members, trustees, officers, or other private persons unless allowed by Section 501(c)(3) of the Code and the Act except that the Corporation shall be authorized and empowered to pay

reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth herein.

(b) No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office.

(c) Notwithstanding any other provisions of the Corporation's governing documents, the Corporation shall not carry on any other activities not permitted to be carried on: (a) by a corporation exempt from federal income tax under Section 501(c)(3) of the Code, or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code.

3.1.13 Operate a hospital and other health care providers and services in furtherance of the charitable purposes described above.

ARTICLE IV
PERIOD OF EXISTENCE

4.1 The period during which the Corporation shall continue is perpetual.

ARTICLE V
MEMBERSHIP

5.1 Members. The Corporation shall have members.

5.2 Identity of Member. There shall be one (1) member of the Corporation who shall be known as the "Corporate Member," and such Corporate Member shall be St. Thomas Baptist Health Corporation, a Tennessee nonprofit corporation.

5.3 Transferability of Membership Interest. The Corporate Member's interest as a member in the Corporation may be transferred by the Corporate Member.

ARTICLE VI
REGISTERED OFFICE, AGENT AND PRINCIPAL OFFICE

6.1 Registered Office and Agent. The street address, zip code and county of the registered office of the Corporation is 4220 Harding Road, Nashville, Davidson County, Tennessee 37205, and the name of the Corporation's registered agent at such address is Sister Priscilla Grimes, D.C.,

6.2 Principal Office. The address of the principal office of the Corporation is 2000 Church Street, Nashville, Davidson County, Tennessee 37236.

ARTICLE VII
BOARD OF TRUSTEES; RESERVED POWERS

7.1 Powers and Responsibilities. The business, property, and affairs of the Corporation shall be managed and controlled by the Corporation's Board of Trustees ("Board of Trustees" or "Board") in accordance with the policies established by the Corporate Member or any successor entity. The Board of Trustees shall act as the board of directors of the Corporation as required by the Act.

7.2 Powers Reserved to Corporate Member. All action of the Corporation shall be by its Board of Trustees, subject to the following matters which require the approval of the Corporate Member:

7.2.1 Approve the mission and vision statements for the Corporation and assure compliance with the philosophy, mission, vision, Sponsor expectations and core values of the System.

7.2.2 Approve changes to the Governing Documents (as that term is generally understood within the Ascension Health system) of the Corporation and its non-controlled subsidiaries that are consistent with the System's Requirements for Governing Documents (as that term is generally understood within the Ascension Health system).

7.2.3 Approve changes to the Governing Documents of the Corporation and its non-controlled subsidiaries that are inconsistent with the System's Requirements for Governing Documents, provided that Ascension Health also approves such changes.

7.2.4 Appoint, upon the recommendation of the Board of the Corporation, or remove, with or without cause, the members of the Board of Trustees of the Corporation. Removal does not require a recommendation of the Corporation's Board.

7.2.5 Approve the incurrence of debt of the Corporation in accordance with the System Authority Matrix (as that term is generally understood within the Ascension Health system).

7.2.6 Subject to canonical requirements, approve and recommend the formation of legal entities, the sale, transfer or substantial change in use of all or substantially all of the assets, divestitures, dissolutions, closures, mergers, consolidations, or changes in corporate membership of the Corporation in accordance with the System Authority Matrix.

7.2.7 Approve the transfer or encumbrance of the assets of the Corporation in accordance with the System Authority Matrix.

7.2.8 Approve the operating budget and capital plan for the Corporation.

7.2.9 Deviate from the polices and restrictions imposed on the Corporation by the Corporate Member.

ARTICLE VIII
DISSOLUTION

8.1 Upon the dissolution of the Corporation, the disposition of all the assets of the Corporation shall be in a manner as provided by the Board of Trustees (subject to the prior approval of the Corporate Member) and in accordance with the following:

8.1.1 The paying of or the making of provision of the payment of all of the liabilities, direct or indirect, contingent or otherwise, including without limitation, all liabilities evidenced in all outstanding loan agreements, credit agreements, master indentures and other similar documents.

8.1.2 Subject to compliance with the dissolution principles of the Corporate Member, all assets remaining after the payment of all of the liabilities of the Corporation shall be distributed, exclusively in furtherance of the religious, charitable, scientific, literary and educational purposes of the Corporation within the meaning of Section 501(c)(3) of the Code, to St. Thomas Baptist Health Corporation or such other exempt organization(s) under Section 501(c)(3) of the Code that is a Subsidiary Organization of St. Thomas Baptist Health Corporation, or to such other exempt organization(s) under Section 501(c)(3) of the Code as shall be determined by the Members of Ascension Health.

8.1.3 Any other assets not so disposed of shall be distributed for one or more exempt purposes within the meaning of Section 501(c)(3) of the Code, or shall be distributed to the federal government, or to a state or local government, for a public purpose. Any such assets not so disposed of shall be disposed of by a court of competent jurisdiction of the county in which the principal office of the Corporation is then located, exclusively for such purposes or to such organization or organizations, as said Court shall determine, which are organized and operated exclusively for such purposes.

This Amended and Restated Charter shall be effective on December 31, 2001.

SETON CORPORATION

By: Thomas E. Burns
President and Chief Executive Officer

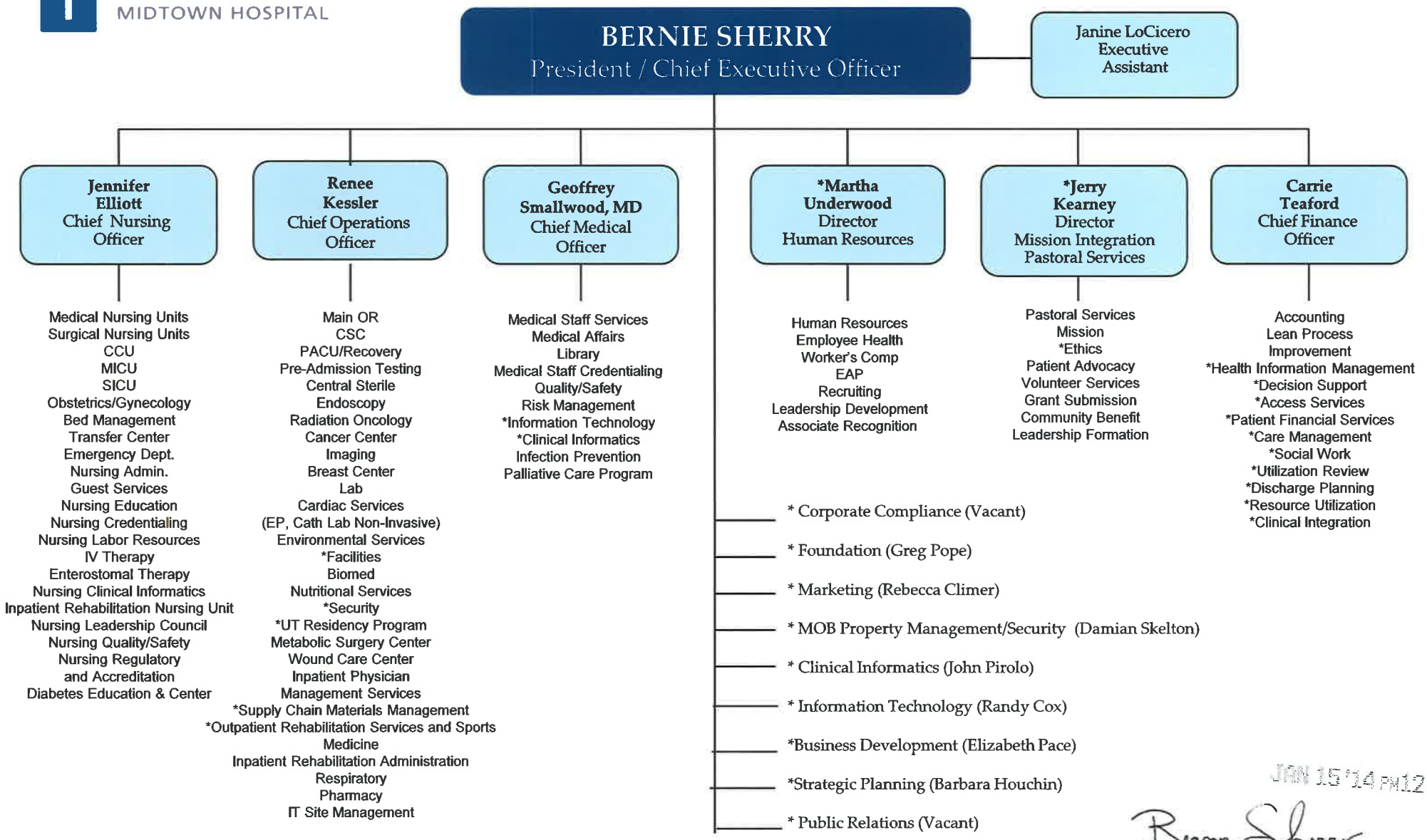
Tab 2

Attachment A, 4

Organizational Chart

Saint Thomas
MIDTOWN HOSPITAL

Organi□ational Chart



JAN 15 '14 PM12:45

Approval - Chief Executive Officer

October, 2013

Date Approved

000078

*Matrix Relationship with Saint Thomas Health and Baptist Executive Team

Tab 3

Attachment A, 4

Board Roster

Saint Thomas
MIDTOWN HOSPITAL

Board of Directors

Updated July 2013

Chairman	Mike Schatzlein, M.D.
Vice Chair	Karen Springer
Secretary/Treasurer	Craig Polkow

Tab 4

Attachment A, 4

Certificate of Corporate Existence

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

ROBERT LIMYANSKY
71 VICKERY STREET
ROSWELL, GA 30075

December 19, 2013

Request Type: Certificate of Existence/Authorization
Request #: 0116387

Issuance Date: 12/19/2013
Copies Requested: 1

Document Receipt

Receipt # : 1240745

Filing Fee: $22.25

Payment-Credit Card - State Payment Center - CC #: 153538236 $22.25

Regarding: Saint Thomas Midtown Hospital
Filing Type: Corporation Non-Profit - Domestic
Formation/Qualification Date: 09/18/2001
Status: Active
Duration Term: Perpetual
Business County: DAVIDSON COUNTY

Control # : 414306
Date Formed: 09/18/2001
Formation Locale: TENNESSEE
Inactive Date:

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

Saint Thomas Midtown Hospital

* is a Corporation duly incorporated under the law of this State with a date of incorporation and duration as given above;

* has paid all fees, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent corporation annual report required with this office;

* has appointed a registered agent and registered office in this State;

* has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 005513821

Tab 5

Attachment A, 6

Deed

This Instrument Was Prepared By:
Jack F. King, Jr., Esq.
Miller & Martin LLP
1200 One Nashville Place
150 4th Avenue North
Nashville, TN 37219

[Property No. 8]

Davidson County DEEDWARR
Recvd: 12/31/01 10:56 4pgs
Fees:23.00 Taxes:621867.65
20011231-0144935

Address New Owner(s):
Seton Corporation
4220 Harding Road
Nashville, TN 37201
Attention: President

Send Tax Bills to
New Owner

Map and Parcel Nos.:
92-11-368.00

SPECIAL WARRANTY DEED

FOR AND IN CONSIDERATION of the sum of Ten and no/100 Dollars ($10.00), cash in hand paid, and other good and valuable considerations, the receipt of which is hereby acknowledged, BAPTIST HOSPITAL SYSTEM, INC., a Tennessee non-profit corporation (the "Grantor"), has this day bargained and sold, and does hereby transfer and convey to SETON CORPORATION, a Tennessee corporation, (the "Grantee"), its successors and assigns, all those tracts or parcels of land described on Exhibit A attached hereto and made a part hereof, together with all rights, privileges, estates, easements, interests and appurtenances belonging or appertaining to said land, all buildings, fixtures and improvements located on the land, and all of Grantor's right, title and interest, if any, in and to the roads, streets, alleys and rights of way, whether open or closed, adjoining said land (collectively, the "real estate").

TO HAVE AND TO HOLD said real estate, with the appurtenances, estate, title and interest thereto belonging, to the said Grantee and its successors and assigns, forever. Grantor covenants with said Grantee that Grantor is lawfully seized and possessed of said land in fee simple subject to those matters set forth as Exhibit B and has a good right to convey it. Grantor further covenants and binds itself, its successors, and assigns to warrant and forever defend the title to said real estate against the lawful claims of all persons claiming by, through or under it, but no further or otherwise.

This is improved property known as 2000 Church Street, Nashville, Tennessee.

Whenever used, the singular shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

EXHIBIT A

A tract or parcel of land located in Nashville, Davidson County, Tennessee, being all of Unit 2 and Unit 3 of the Horizontal Property Regime known as Baptist Hospital created by that certain Master Deed of Baptist Hospital of record as instrument number 20011231-0144920, Register's Office for Davidson County, Tennessee.

Being part of the same property conveyed to Protestant Hospital of Nashville, Inc. by Deed from The Nashville Trust Company, a Tennessee corporation, as appointed receiver of Nashville Protestant Hospital of record in Deed Book 1237, page 440, Register's Office for Davidson County, Tennessee. Protestant Hospital, Inc. having since changed its name to Mid-State Baptist Hospital, Inc. by Amendment to Charter of record in Book 1605, page 533, Register's Office for said County. The said Mid-State Hospital, Inc. having since changed its name to Baptist Hospital System, Inc. by Articles of Amendment to the Charter recorded as instrument number 200009060087961, Register's Office for said County and also being part of the same property conveyed by Master Deed of record as instrument number _____, Register's Office for Davidson County, Tennessee.

Property No. 8
92-11-368.00

EXHIBIT B

PERMITTED EXCEPTIONS

1. Taxes for 2002, a lien not yet due and payable.

2. All matters as shown on Plat of record in Book 161, page 126, Register's Office for Davidson County, Tennessee.

3. A non-exclusive ingress and egress and parking easement created by Section 2.1(g) of the Reciprocal Easement Agreement of record in Book 10547, page 907, as amended in Book 10606, page 864, Register's Office for Davidson County, Tennessee.

4. Shared Services Agreement of record in Book 10511, page 466 and Book 10511, page 333, Register's Office for said County.

5. Unrecorded leases with parties in possession disclosed to Grantee.

6. Master Deed of record as instrument No. 20011231-0174920, Register's Office for Davidson County, Tennessee.

IN WITNESS WHEREOF, Grantor has executed this instrument on this 31 ST day of December, 2001.

BAPTIST HOSPITAL SYSTEM, INC.

By: Erie Chapman
Its: President

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

Before me, the undersigned, a Notary Public in and for the County and State aforesaid, personally appeared Erie Chapman with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself to be President of BAPTIST HOSPITAL SYSTEM, INC., the within named bargainor, a corporation, and that he as such President, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself as President.

Witness my hand and seal, at office in Nashville, Tennessee, this 19th day of December, 2001.

Mary C. Ward
Notary Public

My Commission Expires: 11/26/2005

STATE OF TENNESSEE)
)
COUNTY OF DAVIDSON)

The actual consideration or value, whichever is greater, for this transfer is $ 168,072,337.00

Thomas C. Berman
Affiant

Subscribed and sworn to before me
this 19th day of December, 2001.

Mary C. Ward
Notary Public
My Commission Expires: 11/26/2005

Tab 6

Attachment A, 13

MCO/BHO Participation

Saint Thomas Midtown Hospital Managed Care Contracts List

Plan Name	Products/Network/Payor Name	Plan Type
Aetna / USHealthcare	Aetna HMO (Includes QPOS and US Access), Elect Choice (EPO), Managed Choice POS, Open Choice, Quality Point of Service (QPOS), US Access, National Advantage Plan, Aetna Select, Open Access Aetna Select, Aetna Open Access HMO, Aetna Open Access Elect Choice, Aetna Choice POS, Aetna Choice POS II, Aetna Open Access Managed Choice, Open Choice PPO, Traditional Choice, Aetna Affordable Health Choices PPO	HMO, EPO, POS, PPO, HMO/POS
	Aetna Golden Medicare Plan - HMO, Aetna Golden Choice Plan - PPO, Aetna Medicare Open Plan - Private FFS (PFFS)	Medicare Advantage
Aetna Institutes of Quality Bariatric Surgery Facility	IOQ Bariatric Surgery	Center of Excellence
Aetna Institutes of Quality Orthopedic Care	IOQ Joint Replacement	Center of Excellence
	IOQ Spine Surgery	Center of Excellence
Alive Hospice	Alive Hospice	Direct
Americhoice	Americhoice (aka United HealthCare Plan of the River Valley, Inc.) (Includes Dual Eligible Special Needs Plan - SNP)	TennCare HMO
AMERIGROUP Community Care	AMERIGROUP Community Care	TennCare HMO
	AMERIVANTAGE Medicare Advantage (Includes Dual Eligible Special Needs Plan - SNP)	Medicare Advantage
Avalon Hospice (formerly Trinity Hospice) (STH, MTMC and Hickman added eff. 2/1/10)	Trinity Hospice	Hospice (Inpatient services for Medicare and TennCare Patients)
Beech Street (A Viant Company) (formerly Concentra, Concentra Preferred Systems, Health Network Systems, PPONext, CapCare, MediChoice) *(Purchased by MultiPlan, but networks remain separate until further notice)*	Beech Street (Includes Beech Street Primary Network, Beech Street Complementary Network and Viant Supplemental Networks)	PPO
BC/BS of TN (BCBST)	BlueAdvantage and BlueAdvantage Plus (PFFS) *It is a unique program in that members may use any doctor, specialist or hospital that accepts the BlueAdvantage terms, conditions and payment rate. Prior to providing services to a BlueAdvantage member, providers must agree to the Terms and Conditions of Plan Payment. When Providers choose to extend services to a BlueAdvantage member, they are acknowledging their agreement and are "deemed" to have a contract with BlueCross BlueShield of Tennessee.*	Medicare Advantage Private Fee for Service (PFFS)
	BlueAdvantage Local PPO (effective 1/1/2009)	Medicare Advantage
	Medicare Advantage Regional PPO (effective 9/20/09)	Medicare Advantage
	BlueCoverTN / Blue Network V	PPO
	Access TN (uses BlueSelect / Network S)	PPO
	Cover Kids (uses Blue Select / Network S)	PPO
	Blue Preferred / Network P (includes Suitcase PPO Program/ BlueCard and Federal Employees Standard Option and Basic Option Programs)	PPO
	Blue Select / Network S (Includes Suitcase PPO Program/BlueCard)	PPO
CCN (National network owned by First Health)	CCN (consolidated under First Health Network as of 1/1/07)	PPO
Blue Distinction Center for Bariatric Surgery	Blue Distinction Center for Bariatric Surgery	Center of Excellence
Blue Distinction Center of Knee and Hip Replacement	Blue Distinction Center for Knee and Hip Replancement	Center of Excellence
Blue Distinction Center for Spine Surgery	Blue Distinction Center for Spine Surgery	Center of Excellence
Bluegrass Family Health	Bluegrass Family Health	HMO, PPO, POS, Consumer Directed Health, including HRA and HSA, Self Insured / TPA, Network Leasing
CenterCare Managed Care Programs	Center Care	PPO, POS
Cigna Healthplan	Cigna Healthplan PPO (Includes Starbridge Choice and Great West PPO)	PPO
	Cigna Healthplan HMO and Gatekeeper POS (Includes HMO Fully Insured, Open Access Plus and Network and Great West HMO and POS)	HMO / POS
	Cigna Medicare Access, Cigna Medicare Access Plus Rx (No provider networks or contracts. Members can visit any provider who accepts original Medicare payment and also Cigna's terms and conditions of payment.)	Medicare Private Fee For Service
CorVel Corporation	CorCare	WC
Coventry Health Care (formerly First Health Direct)	Coventry Health Care (formerly First Health Direct) (As of 1/1/07, this replaced the First Health Direct business. It is the directly administered commercial business	PPO
Division of Rehabilitation Services	Division of Rehabilitation Services	Direct
First Health	First Health (As of 1/1/07, this network is part of Coventy Health Care's rental network business, including group health and workers comp. The following networks will be consolidated under the First Health name: CCN, Healthcare Value Management (HCVM) and PPO Oklahoma)	Rental Network (PPO)
FOCUS Healthcare Management *(a wholly owned susidary of Concentra)*	FOCUS	WC
Great West (formerly known as One Health Plan)	Great West / One Health Plan / PPO *(As of 2/1/09, plan will access Cigna PPO)*	PPO
	Great West / One Health Plan / HMO *(As of 2/1/09, plan will acesss Cigna Managed Care)*	HMO
	Great West / One Plan /POS *(As of 2/1/2009, plan will acesss Cigna Managed Care)*	POS
	Great West / Open Access) *(As of 2/1/2009, plan will acesss Cigna Managed Care)*	POS
HealthMarkets Care Assured	Health Markets Care Assured PFFS *(No provider networks or contracts. Members can visit any doctor, specialist or facility who accepts Medicare and HealthMarkets Care Assured's policies)*	Medicare Advantage Private Fee for Service (PFFS)
Health Payors Organization, Ltd. / Interplan Healthgroup	HPO	PPO
HealthSpring (fka Healthnet Management Co.)	HealthSpring HMO, Inc. (Commercial Plans include Primary Plan, Advantage Plan, Freedom Plan, Direct Product Plan and Member Option Plan)	HMO, POS and EPO
	HealthSpring Medicare Advantage	Medicare Advantage
Humana Health Care Plans	Humana HMO, POS, PPO (Including Choice Care) (Includes CHA Prime Network for fully insured HMO, POS and PPO as of 1/1/2009)	HMO, POS PPO
	HumanaChoice PPO and Humana Gold Plus HMO	Medicare Advantage (Contracted)
	Humana Gold Choice Medicare Advantage PFFS *(No provider networks or contracts. Members can visit any doctor, specialist or facilitywho accepts Medicare and Humana's terms)*	Medicare Private Fee For Service

Plan Name	Products/Network/Payor Name	Plan Type
KY Medicaid	Operating 4 MCOs: WellCare, Coventry, Humana, Passport.	Medicaid
MultiPlan (Includes BCE Emergis / ProAmerica) *(MultiPlan purchased PHCS and Beechstreet/Viant. Networks will remain separate until further notice)*	MultiPlan, BCE Emergis, ProAmerica, Up and Up, Formost	PPO
NovaNet	Nova Net	PPO
OccuComp *(*Only STHS Outpatient Rehabilitiation Services)*	OccuComp	WC
Odyssey Healthcare	Odyssey Healthcare	Hospice (Inpatient services for Medicare and TennCare Patients)
Prime Health (formerly known as Comp Plus)	Prime Health (formerly known as CompPlus)	
	Workers Compensation	WC
	Tier I Commmercial	PPO
	Tier II Commercial	PPO
Private Healthcare Systems, Ltd. *(Purchased by MultiPlan. Networks will remain separate until further notice)*	Private Healthcare Systems (PHCS)	PPO & PPO/POS
Pyramid Life - Today's Options	Today's Options Medicare Advantage Private Fee for Service (No provider networks or contracts. Members can visit any doctor, specialist or facility who accepts Medicare and Pyramid's terms)	Medicare Advantage Private Fee for Service (PFFS)
Signature Health Alliance *(BlueGrass purchased Signature Health Alliance. Effective 4/1/10, contracted under BlueGrass with two liers of payment)*	Signature Health Alliance	PPO
Southern Benefit Administrators, Inc.	Southern Benefit Administrators, Inc.	TPA
Starbridge Choice *(Plan falls under Cigna PPO network)*	Starbridge Choice	PPO
Sterling Healthcare (Option 1) *(No contract required)*	Option I	Medicare Advantage, Private Fee for Service
TriCare for Life *(No contract required)*	TriCare for Life	Medicare Supplement for retired military
TRICARE North (HealthNet Federal Services)	TRICARE Standard, TRICARE Prime, TRICARE Prime Remote, TRICARE Extra, TRICARE Reserve Select	TRICARE
TRICARE South (Humana Military)	TRICARE Standard, TRICARE Prime, TRICARE Prime Remote, TRICARE Extra, TRICARE Reserve Select	TRICARE
United Healthcare	United Healthcare: Choice, Choice Plus, Select, Select Plus, Options PPO, Definity HRAs and HSAs	HMO, PPO, POS
	Secure Horizons (fka United Healthcare Medicare Complete)	Medicare Advantage
USA Managed Care Organization	PPO: Includes USA H&W and USA WIN (PPO includes Tennessee Healthcare Group Health)	PPO
	EPO: Includes USA SPAA and USA WIN SPAA (EPO includes Tennessee Healthcare Work Comp) (As of 9/20/2006, Tennessee Healthcare began accessing USA MCO with the exception of State of TN Public Employees (Work Comp) which will remain with Prime Health through 2007)	EPO
Windsor HealthCare	Windsor HealthCare Medicare Advantage	Medicare Advantage

Attachment B

Plot Plan
Maps of Service Area Access
Schematics

Tab 7

Attachment B, III.(A)

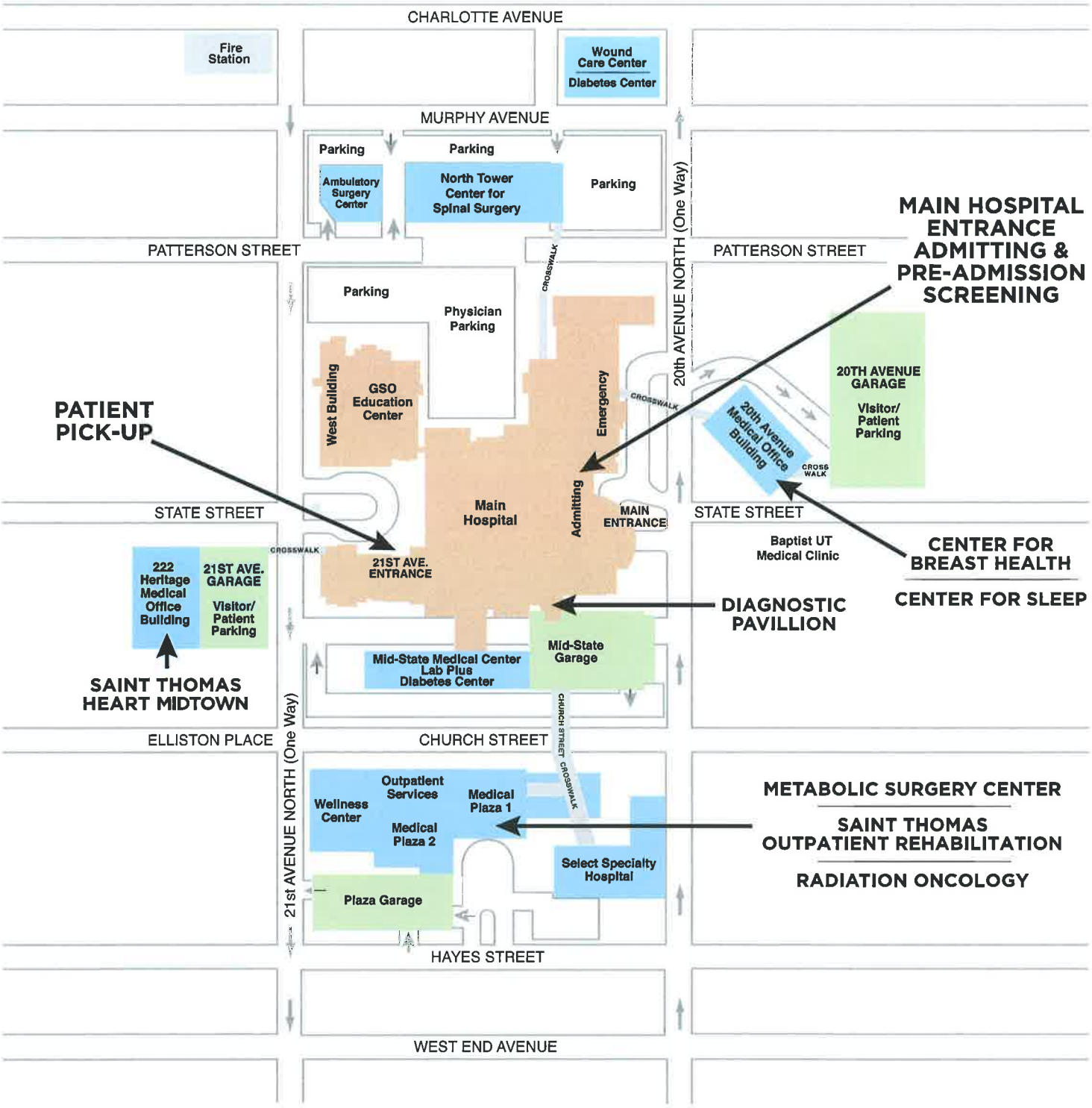
Plot Plan

Saint Thomas
MIDTOWN HOSPITAL

2000 Church St, Nashville, TN 37236
615.284.5555 | www.**STMidtown**.com

Saint Thomas Midtown Hospital is a Tobacco Free campus.

Patient Information: 615.284.5288



Free parking is available for patients and visitors in the 21st Avenue, 20th Avenue and Plaza parking garages. The Mid-State Garage offers free parking for Mid-State Medical Center, obstetrics, joint replacement center and cardiovascular lab patients only (no visitor parking). Free valet parking is available Monday to Friday from 6 a.m. to 6 p.m. at the 20th Avenue Main Entrance to the hospital.

Tab 8

Attachment B, III.(B).1

Maps of Service Area Access

Access to Saint Thomas Midtown Hospital

Nashville MTA

Your ticket to Music City

SYSTEM MAP

MTA Displays Around Town

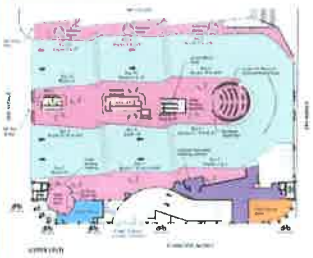
Display Racks of Schedules

1. Andrew Jackson Building, 500 Deaderick Street
2. Andrew Johnson Building, 710 James Robertson Parkway
3. Anthem Career College, 560 Royal Parkway
4. Belmont University, 1900 Belmont Boulevard
5. Bridgestone Arena, 501 Broadway
6. City Hall & Metro Courts, 1 Public Square
7. Daymar Institute, 340 Plus Park Boulevard
8. Davy Crockett Building, 500 James Robertson Parkway
9. Justice A.A. Birch Building, 408 2nd Avenue North
10. Lentz Public Health Center, 311 23rd Avenue North
11. Lincoln College of Technology, 1524 Gallatin Road
12. Looby Center and Library, 2301 Rosa L. Parks Blvd.
13. Metro Board of Education, 2601 Bransford Avenue
14. Metro General Hospital, 1818 Albion Street
15. MTA Madison Headquarters, 430 Myatt Drive
16. Music City Central, 400 Charlotte Avenue
17. Nashville Downtown Library, 615 Church Street
18. Peabody College Post Office, 230 Appleton Place
19. Riverfront Regional Rail Station, 108 1st Ave. North
20. Tennessee Dept. of Human Services, 1000 2nd Avenue North
21. Tennessee Performing Arts Center, 505 Deaderick Street
22. Tennessee State University, 3500 John A. Merritt Blvd.
23. Vanderbilt University Post Office, 2301 Vanderbilt Place
24. Watkins College of Art, Design & Film, 2298 Rosa L. Parks Boulevard
25. William R. Snodgrass Tennessee Tower, 312 7th Avenue North

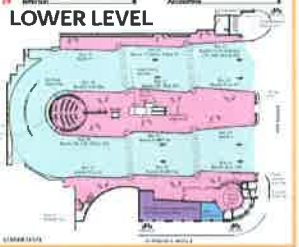
For a list of other locations, please call MTA Customer Care at **(615) 862-5950**.

MUSIC CITY CENTRAL

UPPER LEVEL



LOWER LEVEL



Route	Bay
100 Oaks	11
Belmont	7
West End/White Bridge	6
Shelby	14
West End/Bellevue	5
Lebanon Pike	10
Hillsboro	3
8th Avenue South	3
MetroCenter	2
Charlotte	1
Nolensville Pike	19
Whites Creek	20
Murfreesboro Pike	17
12th Avenue South	11
Airport/Downtown Hotels	13
Herman	4
Scott	17
Bordeaux	12
Dickerson Road	24
Bellevue Express	9
Midtown	21 & 23
Gallatin Pike	18
Old Hickory	8
Meridian	22
Jefferson	3

Route	Bay
McFerrin	22
Hickory Hollow/Lenox Express	13
Opry Mills	10
Rivergate Express	18
Madison Express	6
Tusculum/McMurray Express	23
Antioch Express	7
Cane Ridge Express	21
Golden Valley	2
St. Cecilia/Cumberland	8
Hickory Hills	24
MTA Shuttle	21
Murfreesboro Pike BRT lite	15
Gallatin Pike BRT lite	16
Murfreesboro Express	23
Smyrna/La Vergne Express	23
Gallatin Express	18
Springfield/Joelton Express	6
Franklin/Brentwood Express	2
Hendersonville Express	18
Clarksville Express	22
Spring Hill Express	20
Nashville/Murfreesboro Relax & Ride	1

This state-of-the-art facility is located at 400 Charlotte Avenue between 4th and 5th Avenues North in the Central Business District (CBD).

It serves as the central hub for MTA buses. There are climate-controlled waiting rooms, an MTA staffed information and ticket sales center, customer restrooms and small retail businesses, including Dunkin' Donuts and the Music City Market.

Up to 20,000 customers use the facility each weekday.

MAP KEY

- Exit Loop
- Passenger Waiting
- Retail Space
- Office Space
- Public Meeting Room
- Customer Seating
- Bike Rack

Welcome aboard!

Whether you are a resident or a visitor to Music City, we are pleased that you are considering or already using our transit system. Our city population is increasing and the services of the Nashville MTA are as well. With 45 bus routes, we have a transit system that is connected to all major corridors and many major businesses and tourist attractions. And, demand for service has never been higher.

Recently, the Federal Transit Administration (FTA) gave us the green light to pursue federal funding for Nashville Mayor Karl Dean's proposed Bus Rapid Transit (BRT) project – the Amp, which will connect East and West Nashville. We are now in the project development phase as outlined under FTA's Small Starts grants program and are on track to compete for federal funds for the project. Last spring, the Metro Council approved $75 million in March's FY 2014 capital spending plan to cover design and final engineering for the Amp. Those funds were contingent on acceptance into project development.

In 2013, we expanded service on MTA's route 18 that serves the Nashville airport. Early morning and evening trips were added and the routing changed to serve our new Music City Center convention center and more of the downtown hotels. We've done our best to make the route convenient to visitors and residents alike.

Another great service we offer is our FREE downtown circulator called the Music City Circuit. It is a convenient and efficient way to get around downtown Nashville and the Gulch. Three different routes (Blue, Green and Purple Circuits) offer frequent service to area attractions and businesses throughout the downtown area.

The MTA board and our management team and employees hope you will continue to be one of the thousands who rely on our transit services to get you to your destinations.

Jeff Yarbro
MTA Board Chair

Frequency Chart

(Average number of minutes between bus trips unless otherwise indicated)

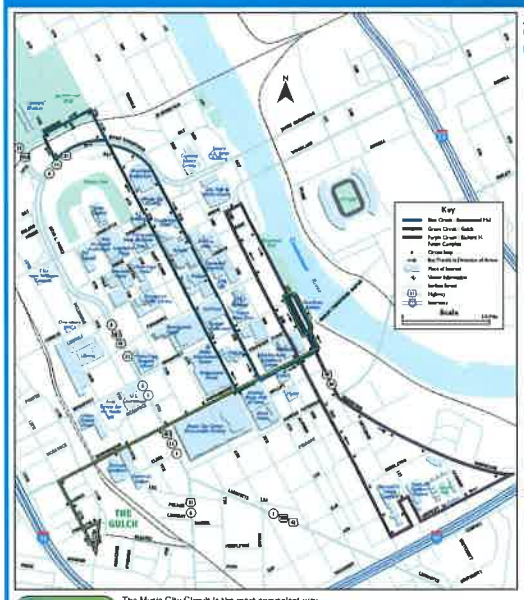
ROUTE	NAME	MONDAY-FRIDAY AM Rush	MONDAY-FRIDAY Midday	MONDAY-FRIDAY PM Rush	MONDAY-FRIDAY Evening	SATURDAY Daytime	SATURDAY Evening	SUNDAY All Day
1	100 Oaks	60	—	60	—	—	—	—
2	Belmont	40	—	40	—	—	—	—
3,5	Core trips for routes 3, 5	10	15	10	20	20	20	20
3	West End/White Bridge	20	30	20	40-60	40	40-60	40
4	Shelby	20	30	20	40-60	40	40-60	40-60
5	West End/Bellevue	20	30	20	40-60	40	40	40
6	Lebanon Pike	15-35	90	15-35	60	—	—	—
7	Hillsboro	20	20	20	40	40	40-60	40-60
8	8th Avenue South	35	75	35	60	60-240	60	60-240
9	MetroCenter	20	30	30	—	—	—	—
10	Charlotte	25	25	25	40	45	45	45
12	Nolensville Pike	10-15	20-30	10-20	60	40	60	60
14	Whites Creek	30	60	25-35	60	60	60	60
15,55	Core trips for routes 15, 55	10-15	10-15	10-15	20-30	10-30	10-30	40
15	Murfreesboro Pike	40	40	40	60	60	60	40
17	12th Avenue South	20-35	20-35	25-35	60	30-60	60	60
18	Airport/Downtown Hotels	60	60	60	60	60	60	60
19	Herman	20	30	20	60	60	60	60
20	Scott	25-30	70	30	60	60	60	60
21	University Connector	30	60	30	60	60	60	60
22	Bordeaux	15-20	22	17	60	30-60	60	60
23	Dickerson Road	20	25	20	60	40	60	60
24X	Bellevue Express	4 Trips	—	4 Trips	—	—	—	—
25	Midtown	35	60	35	60	60	60	60
26,56	Core trips for routes 26, 56	10-15	10-15	10-15	20-30	10-30	10-30	40
26	Gallatin Pike	40	40	40	60	60	60	60
27	Old Hickory	2 Trips	—	2 Trips	—	—	—	—
28	Meridian	25	50	25	50	50	50	50
29	Jefferson	20	30	20	60	60	60	60
30	McFerrin	60	60	60	60	60	60	60
31X	Hickory Hollow/Lenox Express	2 Trips	1 Trip	3 Trips	—	—	—	—
34	Opry Mills	90	90	90	90	90	90	90
35X	Rivergate Express	3 Trips	—	4 Trips	—	—	—	—
36X	Madison Express	3 Trips	2 Trips	3 Trips	—	—	—	—
37X	Tusculum/McMurray Express	2 Trips	—	2 Trips	—	—	—	—
41X	Antioch Express	2 Trips	1 Trip	3 Trips	—	—	—	—
42X	Cane Ridge Express	2 Trips	—	3 Trips	—	—	—	—
41	Golden Valley	60	—	60	—	—	—	—
42	St. Cecilia/Cumberland	30-55	50-65	25-30	60	60	60	60
43	Hickory Hills	25-50	125-150	50-60	—	—	—	—
44	MTA Shuttle	30	20-25	30	—	—	—	—
55	Murfreesboro Pike BRT lite	15	15	15	30	30	30	—
56	Gallatin Pike BRT lite	15	15	15	30	30	30	—
71	Edmondson Pike Connector	60	60-180	60	60	—	—	—
76	Madison Connector	60	60	60	60	60	—	—
86X	Murfreesboro Express	3 Trips	—	3 Trips	—	—	—	—
88X	Smyrna/La Vergne Express	3 Trips	—	3 Trips	—	—	—	—
97X	Gallatin Express	2 Trips	—	3 Trips	—	—	—	—
98X	Springfield/Joelton Express	2 Trips	—	2 Trips	—	—	—	—
91X	Franklin/Brentwood Express	3 Trips	—	3 Trips	—	—	—	—
92X	Hendersonville Express	2 Trips	—	3 Trips	—	—	—	—
81	Music City Star West End Shuttle	3 Trips	—	3 Trips	—	—	—	—
94X	Clarksville Express	3 Trips	—	3 Trips	—	—	—	—
80X	Spring Hill Express	2 Trips	—	2 Trips	—	—	—	—
90X	Nashville/Murfreesboro Relax & Ride	4 Trips	8 Trips	4 Trips	3 Trips	—	—	—

Key to Routes

- **Most frequent routes** (Daytime frequencies every 30 minutes or less)
- **Frequent routes** (Daytime frequencies generally 30-90 minutes)
- **Limited services** (Limited or express service)

This frequency chart is not definitive and should only be used as a guide. Please consult individual route schedules for further information.

MUSIC CITY CIRCUIT — RIDE FREE!



Attractions along the routes:

Blue Circuit
- Arcade
- Bicentennial Mall
- Bridgestone Arena
- Country Music Hall of Fame
- Farmers' Market
- Hatch Snow Print
- Municipal Auditorium
- Music City Center (Convention Center)
- Music City Central (Transit Station)
- Printers Alley
- Riverfront Station
- Ryman Auditorium
- Schermerhorn Symphony Center
- Tennessee Performing Arts Center (TPAC)
- Tennessee State Museum

Green Circuit
- Country Music Hall of Fame
- Cummins Station
- Gulch Restaurants and Bars
- Music City Center (Convention Center)
- Riverfront Station
- Schermerhorn Symphony Center

Purple Circuit
- City Hall & Metro Courts
- Nashville Children's Theatre
- Richard H. Fulton Complex (Metro Offices)
- Riverfront Station

The Music City Circuit is the most convenient way to get around downtown Nashville and the Gulch. Whether you live or work Downtown or you're visiting for business or pleasure, the Music City Circuit will get you where you need to go quickly and easily. Dining, entertainment and shopping are all at your fingertips without parking hassles, and our clean fuel vehicles help lower vehicle emissions.

Frequent stops all around Downtown and the Gulch make it a breeze to get to your favorite restaurant, the hottest concert, or anywhere else in between. Just board the Music City Circuit at one of the designated stops with the blue-and-green sign.

	MONDAY-FRIDAY AM	MONDAY-FRIDAY Midday	MONDAY-FRIDAY PM	MONDAY-FRIDAY Evening	SATURDAY Daytime	SATURDAY Evening
Blue Circuit	30	15	15	—	15	—
Green Circuit	30	15	15	15	15	15
Purple Circuit	—	15	—	—	—	—

General Information

Bus Stops

Most MTA bus stops are marked with a blue-and-white sign. If bus stop signs have not yet been installed on your bus route, please go to the nearest intersection of the street traveled by your bus and flag it down when it comes into view.

Destination Signs

Every MTA bus is marked with a route number as well as the destination name or area. All Express Routes are designated by an "X" following the route number. As you get on an MTA bus, if you have questions about where the bus is going, please ask the driver.

Park & Ride

Several bus routes provide Park & Ride service that allows you to park your car and ride an MTA bus. MTA passengers are permitted to use Park & Ride lots as complimentary services by owners of the lots. Please refer to the list above the system map or on the route schedules for locations.

Holiday Service

On the following major holidays MTA operates service on a Sunday/Holiday schedule:

- New Year's Day
- Labor Day
- Memorial Day
- Thanksgiving
- Independence Day
- Christmas

On Martin Luther King Jr. Day MTA operates service on a Saturday schedule.

Snow Routes

Be prepared for winter weather and pick up your MTA snow route brochure today.

Snow route information may be found at MTA displays around town, on MTA buses, online at nashvillemta.org or by calling Customer Care at **(615) 862-5950**.

Services for Medicare Cardholders,

Seniors or People with Disabilities Medicare cardholders, who are not elderly or disabled, qualify for a reduced MTA fare of 85 cents on MTA buses with their Medicare ID. Seniors age 65 and older and people with disabilities qualify for a reduced MTA fare of 85 cents on MTA buses with one of the following ID cards: Medicare, Senior-MTA Golden Age, or driver's license; Disabled-Medicare, MTA Special Service, or other transit ID card for the disabled. Passengers whose disabilities prevent them from using the large MTA buses may qualify for special door-to-door van service through the MTA AccessRide Program. Please call the MTA AccessRide Office at **(615) 880-3970** for more information or visit the MTA website at nashvillemta.org

Music City Central

Music City Central serves as the central hub for MTA buses and is the main transfer point. It is located at 400 Charlotte Avenue between 4th and 5th Avenues North in the Central Business District.

How Much are the Fares?

Adult

Adult (Local, Airport & BRT lite Services) $1.70
Adult (Express Service) $2.25
Senior (ages 65 and older, please show driver proof of age before depositing fare) ..... $ .85
People with Disabilities and Medicare cardholders (please show driver special identification card before depositing fare) ..... $ .85

Youth

Youth Fare (ages 19 and younger, please alert driver before depositing fare and be prepared to show proof of age upon request) $1.00
Children ages 4 and younger ..... No Charge

MTA Passes Available – For your convenience, passes are available for purchase at Music City Central (400 Charlotte Avenue), by phone at **(615) 862-5950** or online at nashvillemta.org. In addition, passes may be requested via mail by sending the request to the MTA Administrative Office address. The All-Day Pass also is available for purchase on MTA buses.

All-Day Pass	$5.25
All-Day Discounted Pass	$2.25
All-Day Youth Pass	$2.50
20 Ride Local	$32.00
20 Ride Express	$42.00
7-Day Pass	$24.00
31-Day Pass	$84.00
20 Ride Discounted Pass	$17.00
31-Day Discounted Pass	$44.00
Quest 7-Day Youth Pass	$16.00
Quest 31-Day Youth Pass	$56.00

* MTA's passes are valid for trips within Davidson County and are not valid for RTA services.

Express Upgrades – Deposit an extra 50 cents to use a 20-Ride Local Pass on an express bus.

Cash, checks, money orders and credit cards are accepted for these purchases. A shipping fee will be applied to all mail, phone and online orders.

000102

Travel Training

Travel Training or "Bus Riding 101" is a service that teaches people with and without disabilities how to ride Nashville MTA buses. Trainers work one-on-one with customers to give them the practice they need to feel confident riding MTA buses. Group orientations, including trips on buses to destinations on our many bus routes, also are available.

There is no charge for travel training; however, individuals must pay the standard bus fare. Seniors age 65 and older, people with disabilities, Medicare cardholders and youth ages 19 and younger are eligible for a discounted fare.

For more information, call **(615) 880-3987** or visit our website at nashvillemta.org

AccessRide

MTA's paratransit service operates a fleet of special vans for people with disabilities who are unable to ride the large fixed-route buses.

- This door-to-door service is provided within Davidson County.
- To request an eligibility application, call AccessRide at (615) 880-3970 or download a copy from the MTA website at nashvillemta.org

Transit Partnerships

MTA partners with Google to provide customers with a public transit trip planning feature on Google maps.

Visit transit.google.com to find bus stops, transit directions and schedules.

EasyRide

EasyRide — This service is designed to help employers incorporate commuter benefits into their benefits plan. For more information, contact MTA at **(615) 862-5969** or ask your Human Resources Director about commuter benefits.

To receive the latest MTA news in your e-mail inbox, sign up for our eNews service at nashvillemta.org

MTA Office Hours

Customer Care Call Center
(615) 862-5950
- Monday-Friday 6:30 a.m. to 6:30 p.m.
- Saturday 8:00 a.m. to 5:00 p.m.
- Sunday 10:30 a.m. to 2:30 p.m.
- Closed holidays

Ticket Sales and Information at Music City Central
400 Charlotte Avenue
- Monday-Friday 6:00 a.m. to 6:30 p.m.
- Saturday 8:00 a.m. to 5:00 p.m.
- Sunday 10:30 a.m. to 2:30 p.m.
- Closed holidays

Music City Central – Hours of Operation
400 Charlotte Avenue
- Monday-Friday 5:15 a.m. to 11:15 p.m.
- Saturday 6:00 a.m. to 10:15 p.m.
- Sunday and holidays 6:00 a.m. to 9:15 p.m.

MTA Administrative Offices
(615) 862-5969
430 Myatt Drive
- Monday-Friday 8:00 a.m. to 4:30 p.m.
- Closed weekends and holidays

Metropolitan Transit Authority
430 Myatt Drive, Nashville, TN 37115
ADA Coordinator and Customer Care:
(615) 862-5950 nashvillemta.org
@Nashville_MTA

Note: For free service in the downtown area, please see the Music City Circuit routes on the reverse side of the map.

Points of Interest

No.	Location	Served by Route	Grid Ref.
1	100 Oaks Mall	1, 17	E3
2	Adventure Science Center	1, 23	D3
3	Airport, Nashville International	18	D4
4	Belle Meade Plantation	9	E1
5	Belmont University	6, 21	D2
6	Bicentennial Mall & Farmers' Market	19, 22, 28, 42	D2
7	Bordeaux Long Term Care	22	C2
8	Bridgestone Arena	10, 18, 18, 34, 83 BRT Rte	Downtown
9	Centennial Medical Center	10, 23	D2
10	Centennial Park & Parthenon	5, 6, 23, 23	D2
11	City Hall & Metro Courts	26, 50, 34, 38X, 41	Downtown
12	Country Music Hall of Fame	12, 18, 18, 34, 83 BRT Rte	Downtown
13	Criminal Justice Center	26, 38, 50, 34, 38X, 41	Downtown
14	Dell Corporation	18, 83 BRT Rte	E4
15	Donelson Regional Rail Station	4, 34	C4
16	Downtown Library	3, 5, 6, 7, 8, 17	Downtown
17	Fisk University	19, 21, 25, 28	D2
18	Fort Negley Park	6, 26, 27, 38X, 44, 83	Downtown
19	Frist Center for the Visual Arts	3, 6, 7, 17	Downtown
20	Gaylord Opryland Resort & Convention Center	34	C4
21	Greer Stadium	1, 28	D3
22	Greyhound Bus Station	12, 18, 18, 83 BRT Rte 84X, 38X, 38X	D3
23	Hermitage Regional Rail Station	6, 27	C5
24	Justice A.A. Birch Building	26, 50, 34, 38X, 41	Downtown
25	Juvenile Justice Center	4, 14, 20, 23, 43	Downtown
26	Lentz Village	38X	F4
27	Lentz Public Health Center	19, 28	D2
28	Lipscomb University	6, 8, 23	E2
29	Looby Center	6, 42	C2
30	LP Field	4, 14, 20, 23, 43	Downtown
31	The Mall at Green Hills	2, 7, 51	E2
32	Meharry Medical College	19, 21, 25, 28	D2
33	Metro General Hospital at Meharry	19, 21, 25, 28	D2
34	MTA Madison Headquarters	27, 38X, 79	B4
35	Municipal Auditorium	All (except 21, 72, 79)	Downtown
36	Music City Central (Transit Station)	All (except 21, 72, 79)	Downtown
37	Music City Center (Convention Center)	1, 2, 6, 12, 18, 34, 83 BRT Rte, 93	Downtown
38	Music Valley Village	34	C4
39	Nashville State Technical Institute	3	D1
40	Opry Mills	34	C4
41	Richard H. Fulton Complex	4, 12, 18, 18, 28, 38X	D3
42	Riverfront Regional Rail Station	6, 26, 27, 38X, 44, 83	Downtown
43	RiverGate Mall	26, 38X, 83 BRT Rte	A4
44	Rochelle Center	8, 17	D3
45	Ryman Auditorium	12, 18, 18, 34, 83 BRT Rte	Downtown
46	Schermerhorn Symphony Center	12, 18, 18, 34, 83 BRT Rte	Downtown
47	Shelby Park	4	D3
48	Skyline Medical Center	43	B3
49	Social Security Office (MetroCenter Branch)	9	C2
50	Social Security Office (Rivergate Branch)	28	A4
51	St. Thomas Midtown Hospital	10, 28	D2
52	St. Thomas West Hospital	3, 8	D2
53	State Capitol	All (except 21, 72, 79)	Downtown
54	State Library & Archives	All (except 21, 72, 79)	Downtown
55	Summit Medical Center	23	D5
56	Tennessee Performing Arts Center	All (except 21, 72, 79)	Downtown
57	Tennessee School for the Blind	8	D2
58	Tennessee State Fairgrounds	1, 12	D3
59	Tennessee State University	19, 21, 28	D2
60	Tennessee State Training Facility	8	C2
61	Trevecca Nazarene University	10, 18, 28 BRT Rte	D3
62	Union Station Hotel	3, 6, 7, 17	Downtown
63	Vanderbilt University	3, 6, 7, 12, 18, 38X, 83X, 84X, 92X, 93	D2
64	Vanderbilt University Medical Center	7, 21, 25, 38X, 83X, 84X, 92X, 93	D2
65	Veterans Administration Hospital	7, 21, 83X, 84X, 92X, 93	D2
66	Zoo (Nashville Zoo at Grassmere)	12	E1

Park & Ride Lots

Letter	Location	Route	Grid Ref.
A	Belle Forest Park & Ride	6, 24X	A1
B	Dollar General	12, 27X	F4
C	Donelson Regional Rail Station	6, 24	D4
D	The Fellowship at Two Rivers	24	C4
E	Hermitage Regional Rail Station	6, 27	C5
F	Hickory Hollow	18, 38X, 84 BRT Rte	F5
G	Hillwood Park & Ride	93	D1
H	Hunters Lane High School Park & Ride	43	B2
I	Kmart - Goodlettsville	88X	A4
J	Kmart - Madison	26, 34, 84 BRT Rte	B3
K	Kohl's - Hendersonville	92X	A5
L	Lakewood Park & Ride	27	B5
M	Madison Square	26	B4
N	MTA Bellevue Park & Ride	6, 24X	A1
O	MTA Madison Park & Ride	27, 38X, 76	B4
P	RiverGate Park & Ride	38X	A4
Q	Smith Springs Church of Christ	38X	E5
R	Southminster Presbyterian Church	12	E3
S	Staples Park & Ride	6, 24X	A3
T	Temple Baptist Church	22	C2
U	Una Church of Christ	16	E4
V	Walmart Park & Ride	38X	F4
W	Whites Creek High School Park & Ride	43	B2

NASHVILLE System Map

Nashville MTA

BELLEVUE INSET

BELLEVUE

WHITES CREEK

HENDERSONVILLE

MADISON

OLD HICKORY

LAKEWOOD

BORDEAUX

HERMITAGE

DOWNTOWN

DONELSON

HICKORY BEND

John C Tune Airport

Cumberland River

Stones River

Old Hickory Lake

KEY

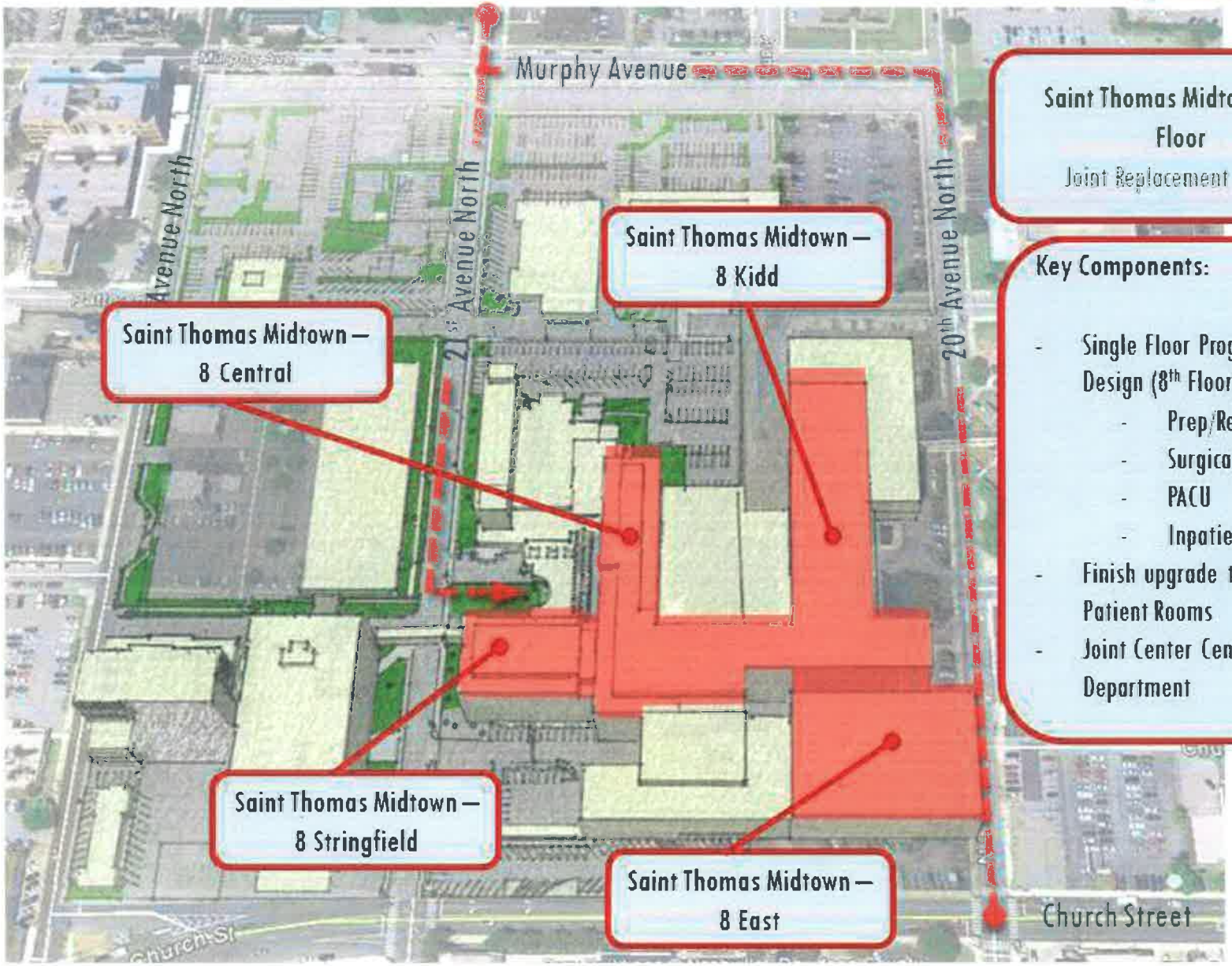
Tab 9

Attachment B, IV

Schematics

Saint Thomas Joint Replacement

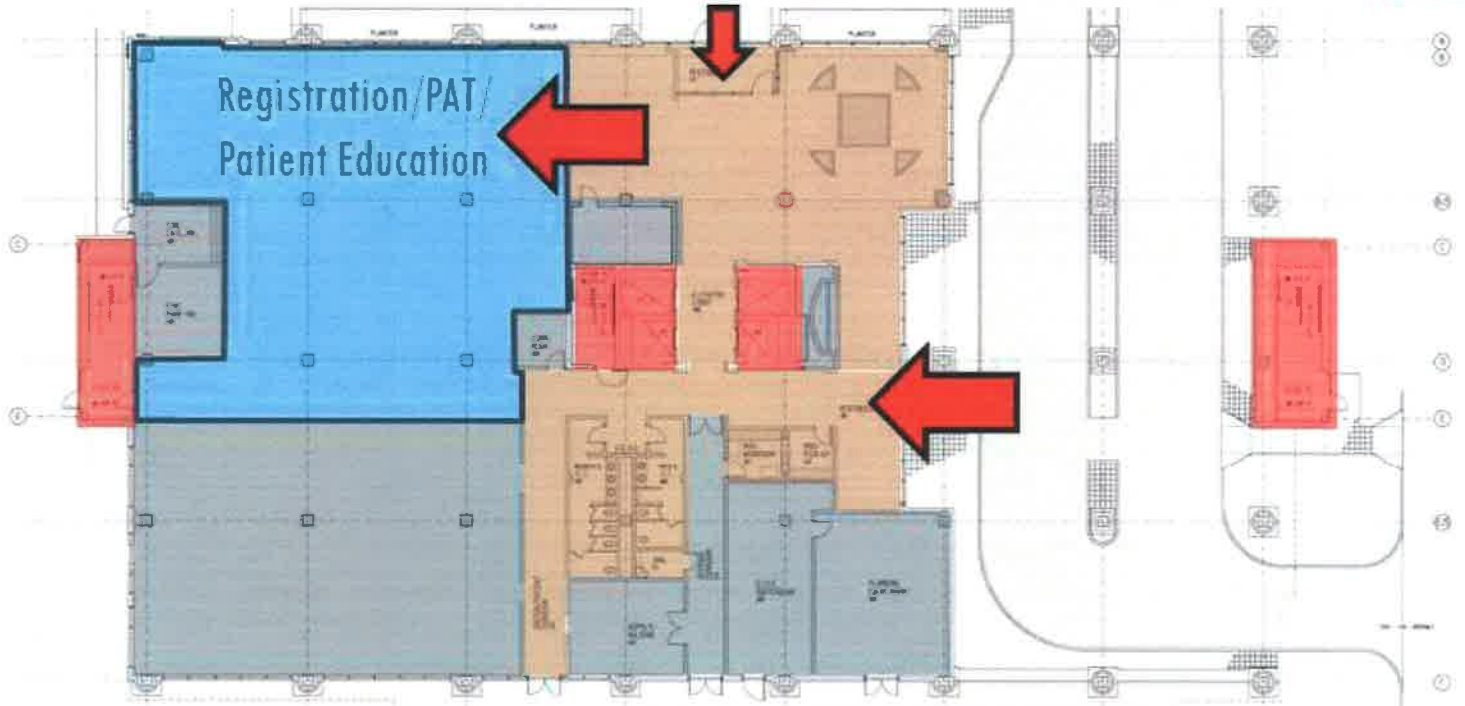
FreemanWhite



Saint Thomas Midtown – Joint Replacement Center – 8th Floor

Saint Thomas Joint Replacement

FreemanWhite

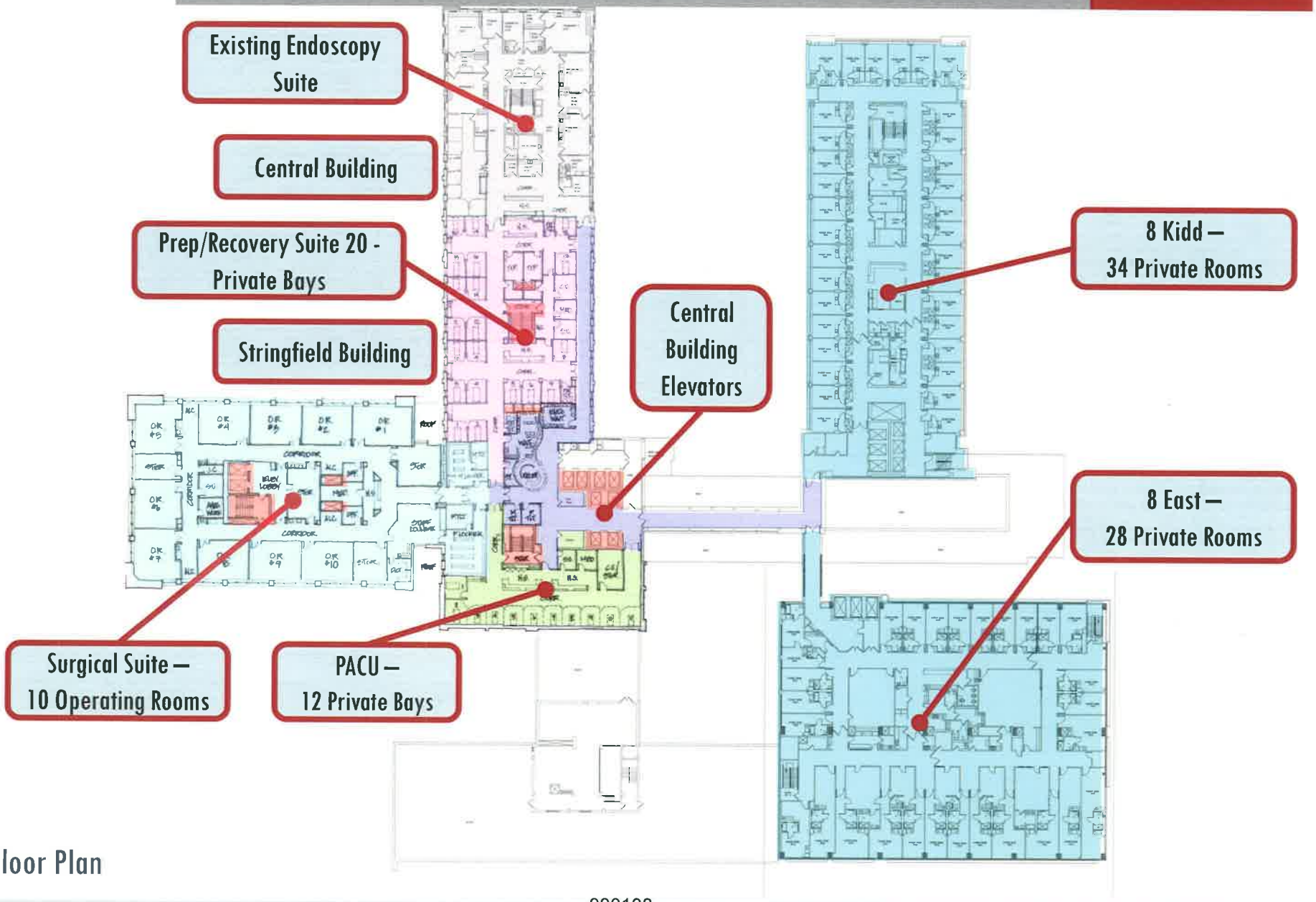


North Tower – 1st Floor

North Tower – Registration/PAT/Education

Saint Thomas Joint Replacement

FreemanWhite



8th Floor Plan

000108

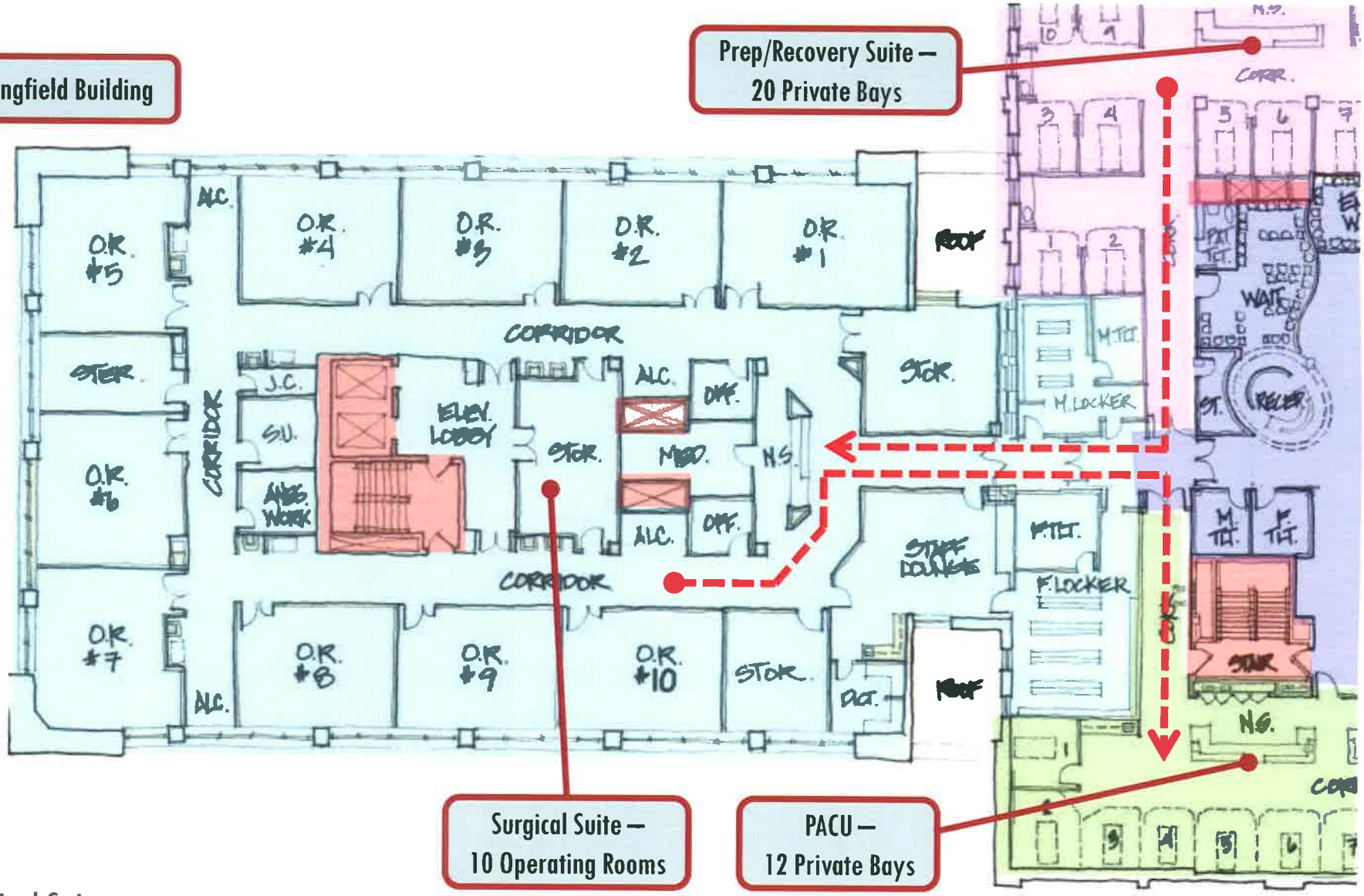
Saint Thomas Midtown – Joint Replacement Center – 8th floor

Saint Thomas Joint Replacement

FreemanWhite

Stringfield Building

Prep/Recovery Suite – 20 Private Bays



Surgical Suite – 10 Operating Rooms

PACU – 12 Private Bays

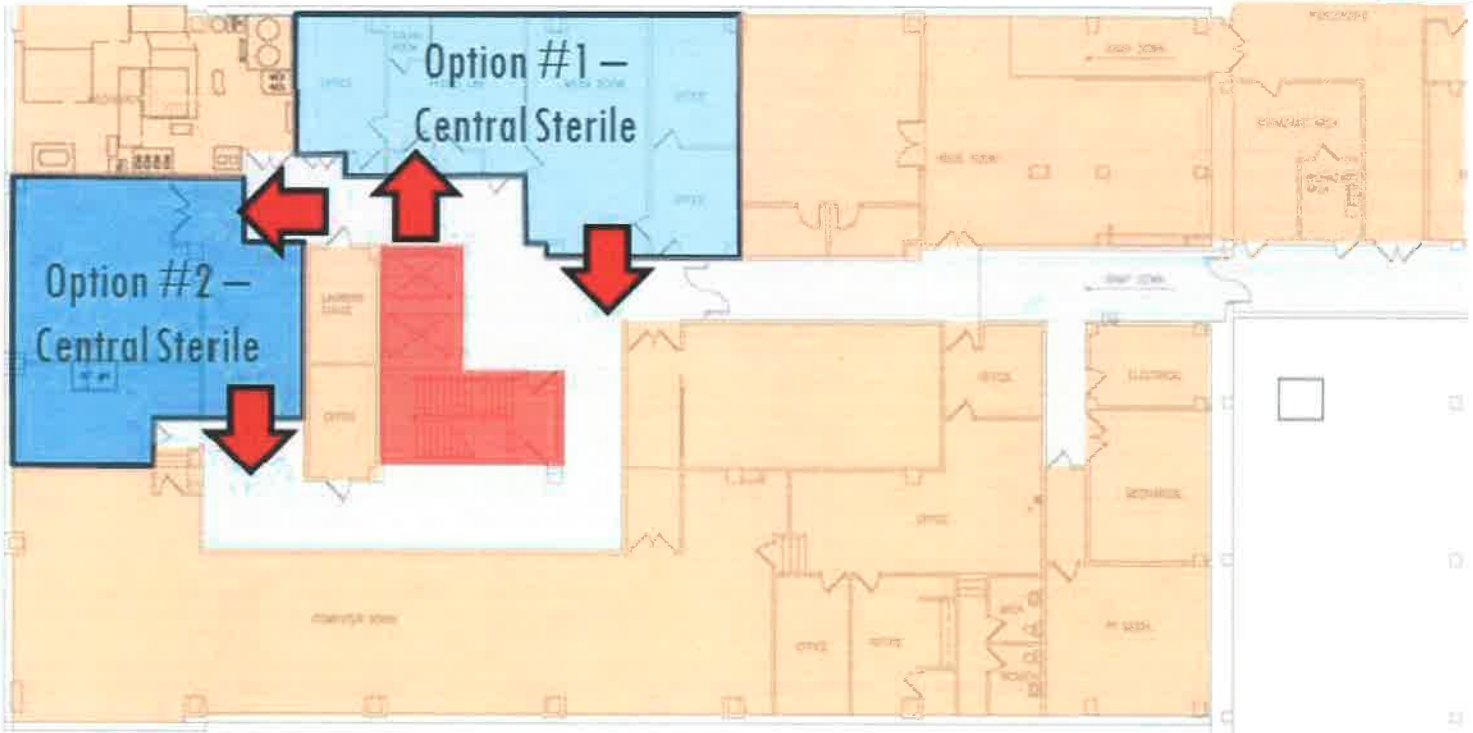
Surgical Suite

000109

Saint Thomas Midtown – Joint Replacement Center– 8th floor

Saint Thomas Joint Replacement

FreemanWhite

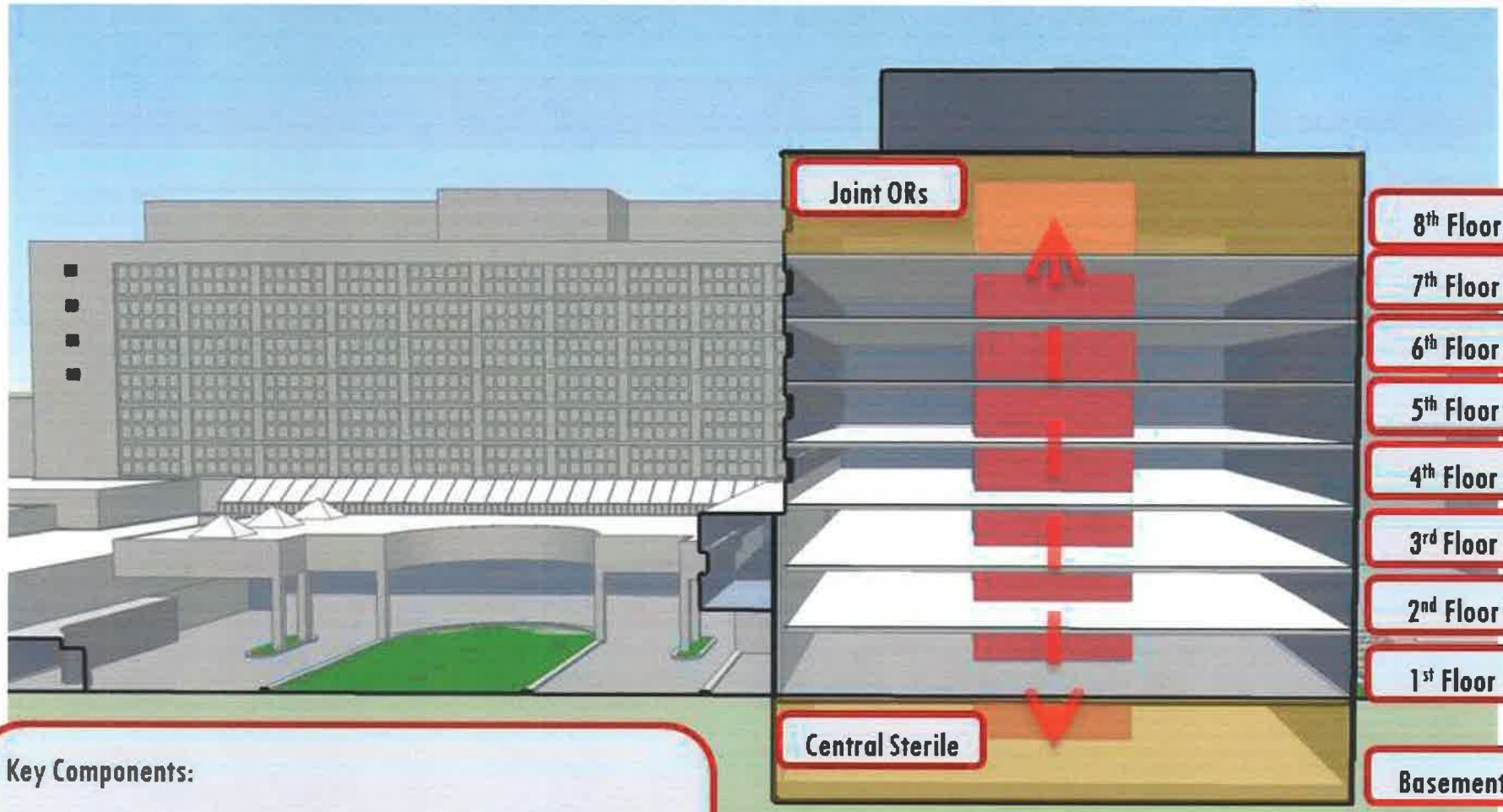


Saint Thomas Midtown – Basement Level

Saint Thomas Midtown – New Joint Central Sterile Processing

Saint Thomas Joint Replacement

FreemanWhite



Key Components:

- Dedicated elevator from 8th floor Surgical Suite to Basement level (Central Sterile)
- Dedicated Central Sterile Department to the Joint Replacement Center

Saint Thomas Midtown – Relationship to New Joint Central Sterile Processing

Attachment C

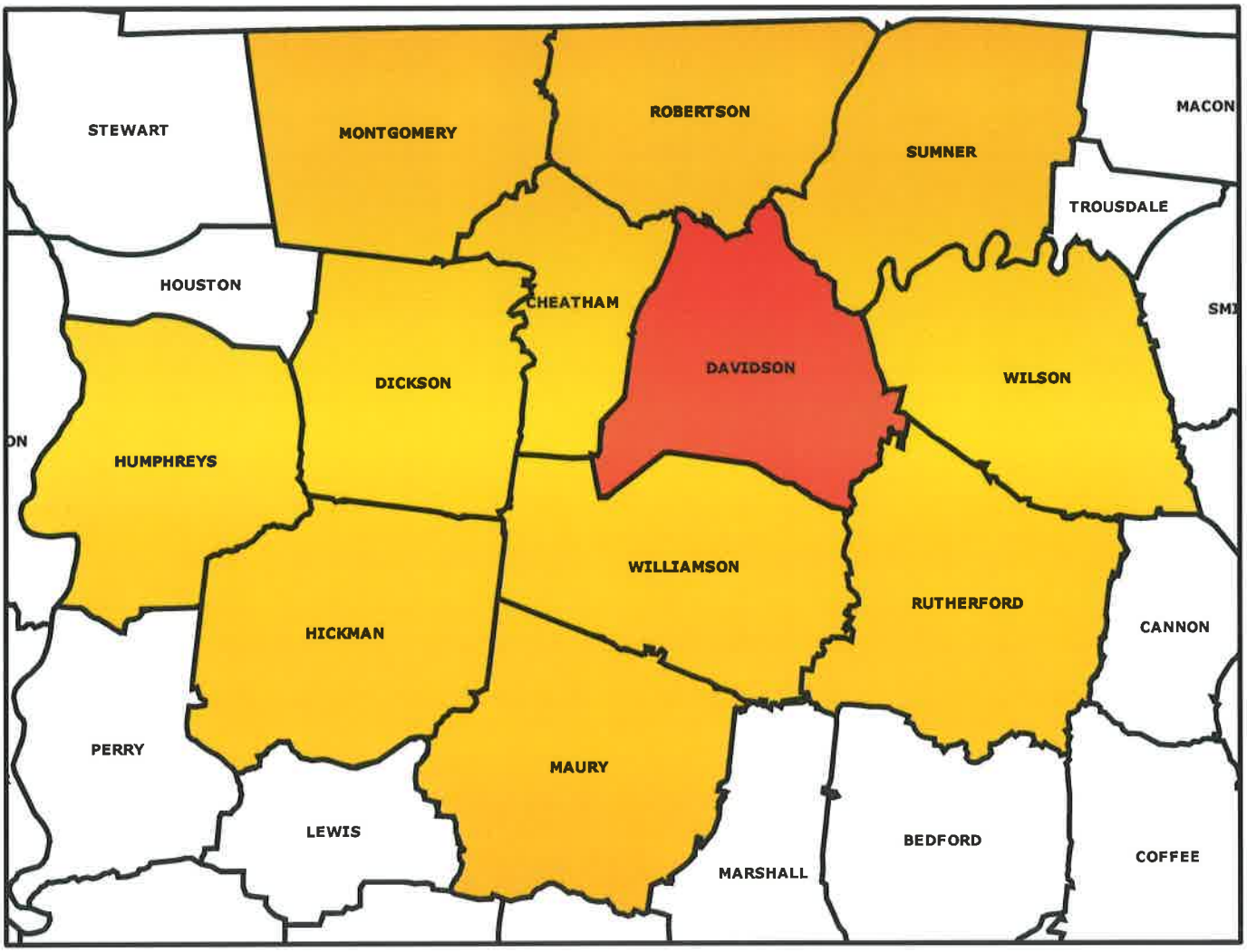
Service Area Map
TennCare Population Data
Construction Costs Verification Letter
Verification of Funding
Balance Sheet and Income Statement
Audited Financials
Letters of Support
Performance Improvement Plan
Utilization Review Plan
Patient Bill of Rights
The Joint Commission Documentation
Hospital License
Inspection Report
Plan of Corrective Action

Tab 10

Attachment C
Need - 3

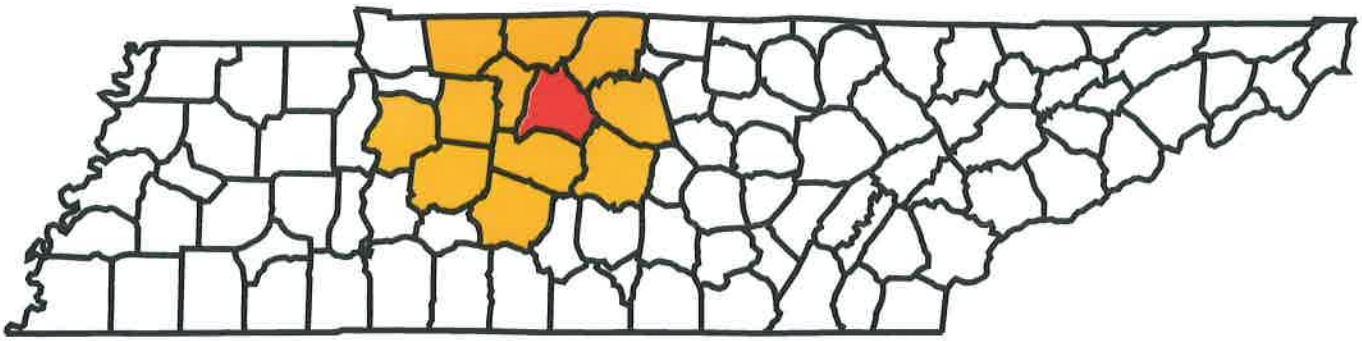
Service Area Map

Service Area Map



Primary Service Area

Secondary Service Area



Tab 11

Attachment C
Need - 4

TennCare Population Data

Service Area TennCare Population
September 2013

Service Area Counties	TennCare Enrollees	2013 Population	% Enrolled
Cheatham	6,204	39,028	15.9%
Davidson	119,726	645,722	18.5%
Dickson	8,939	50,556	17.7%
Hickman	5,194	24,053	21.6%
Humphreys	3,434	18,381	18.7%
Maury	14,601	82,133	17.8%
Montgomery	23,540	181,674	13.0%
Robertson	10,969	68,061	16.1%
Rutherford	36,781	276,375	13.3%
Sumner	23,207	167,264	13.9%
Williamson	8,441	194,928	4.3%
Wilson	14,575	119,707	12.2%
Total SA	**275,612**	**1,867,882**	**14.8%**
Tennessee	1,198,663	6,469,063	18.5%

Sources: Nielsen, Inc., Bureau of Tenncare

Tab 12

Attachment C
Economic Feasibility - 1

Construction Costs Verification Letter

Turner Healthcare

January 14, 2014

Mr. Bernie Sherry
Saint Thomas Midtown Hospital
2000 Church Street
Nashville, TN 37236

RE: Saint Thomas Midtown Hospital
Orthopedic Center of Excellence
Conceptual Estimate

Mr. Sherry:

This letter is being issued as verification that the submitted estimate of cost for the proposed OR renovation project (& associated support spaces) at Saint Thomas Midtown Hospital is reasonable. The aggregate construction cost estimate of $13,450,569 (94,337SF @ $142.58 / SF) is based on comparative estimates of similar construction and adjusted local trades. In addition, the overall comprehensive project cost of $25,832,609 is also comparable to similar projects.

I attest that the design and construction information submitted is consistent with the design and cost of similar facilities in the region. The physical environment will conform to the applicable federal, state, and local construction codes, standards, manufacturers' specifications and licensing agencies requirements, including the current 2010 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

We hope this meets with your approval and stand ready to answer and questions that you may have. As always, we look forward to assisting in the development of this project. Please feel free to call me with any questions, clarifications, or comments.

Sincerely,
Turner Construction

W. Kevin Williams
Sr. Project Manager

CC: File

Tab 13

Attachment C
Economic Feasibility - 2

Verification of Funding

Saint Thomas Health

January 13, 2014

Ms. Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Certificate of Need Application - Saint Thomas Midtown Hospital

Dear Ms. Hill:

Saint Thomas Health has a centralized cash management program for managing and investing operating funds for all Saint Thomas Health hospitals, including Saint Thomas Midtown Hospital. This letter is to confirm that Saint Thomas Health has available more than sufficient resources to fund the projected cost of $25,832,609 required to implement the project to renovate surgical suites, patient care areas and support space for consolidation of total joint replacement services at Saint Thomas Midtown Hospital.

Thank you for your attention to this matter.

Sincerely,

Craig Polkow
Chief Financial Officer

102 Woodmont Blvd., Suite 800
Woodmont Centre
Nashville, TN 37205
SaintThomasHealth.com

Saint Thomas Health

Saint Thomas Health
Consolidated Balance Sheet
As of June 30, 2013
(Dollars in Thousands)

	June 30, 2013
ASSETS:	
Cash and investments	$ 12,647
Patient accounts receivable	417,372
Less allowances	(278,816)
Net accounts receivable	138,556
Estimated settlements from 3rd party payors	7,637
Current portion of assets limited to use	502
Inventory	15,816
Other current assets	25,858
Total Current Assets	201,016
Trusteed assets	30,239
Assets Limited to Use	30,239
Other Long-Term Investments	605,467
Property, plant, equipment cost	1,160,253
Construction in progress	32,668
Less accumulated depreciation	(724,421)
Total Property, Plant & Equipment	468,500
Investment in unconsolidated entities	36,252
Assets held for sale	-
Advances to affiliated entities, net	2
Other miscellaneous assets	71,252
Total Other Assets	107,506
TOTAL ASSETS	**$ 1,412,728**

	June 30, 2013
LIABILITIES:	
Current maturities of long-term debt	$ 6,400
Accounts payable	34,912
Accrued liabilities	45,398
Estimated third party payor settlement	16,585
Current portion of self-insurance liability	10,023
Other current liabilities	34,092
Total Current Liabilities	147,410
Long-term Debt	407,177
Self-insurance liability	3,069
Other non-current liabilities	29,262
Other Non-Current Liabilities	32,331
TOTAL LIABILITIES	586,918
NET ASSETS:	
Unrestricted net assets	792,910
Unrestricted net assets noncontrolling interest	2,158
Temporarily restricted net assets	28,455
Permanently restricted net assets	2,287
TOTAL NET ASSETS	825,810
TOTAL LIABILITES AND NET ASSETS	**$ 1,412,728**

Tab 14

Attachment C
Economic Feasibility - 10

Balance Sheet and Income Statement

Saint Thomas Midtown Hospital
Balance Sheet
(Dollars In Thousands)

	June 30, 2013
ASSETS	
CURRENT ASSETS:	
Cash and Cash Equivalents	$2
Gross Patient Accounts Receivable	132,559
Less Allowances	(87,216)
Patient Accounts Receivable, Net	45,343
Estimated Settlements from Third-Party Payors	1,562
Total Inventory	4,557
Total Other Current Assets	342,559
Total Current Assets	**$394,024**
PROPERTY AND EQUIPMENT:	
Land and Improvements	$7,638
Buildings	221,155
Equipment	117,863
Construction in Progress	13,741
Less Accumulated Depreciation	(255,839)
Total Property and Equipment, (net)	**$104,558**
OTHER ASSETS:	
Investments in Unconsolidated Entities	$980
Other	9,273
Total Other Assets	**$10,253**
Total Assets	**$508,836**

	June 30, 2013
LIABILITIES AND NET ASSETS	
CURRENT LIABILITIES:	
Current Portion of Long-Term Debt	$3,530
Accounts Payable	9,569
AR Credit Balances, net	2,883
Accrued Liabilities	9,893
Estimated Settlements to Third Party Payors	5,276
Current Portion Self-Insurance Liability	2,749
Total Other Current Liabilities	70,274
Total Current Liabilities	**$104,173**
NONCURRENT LIABILITIES:	
Long-Term Debt:	
Centralized Debt Management System	$241,720
Net Long-Term Debt	**$241,720**
Other Long-Term Liabilities:	
Self-Insurance Liability	$1,293
Pension and Other Post-Retirement Benefits	3,300
Other	2,395
Total Noncurrent Liabilities	**$248,707**
Total Liabilities	**$352,880**
NET ASSETS:	
Unrestricted Net Assets	$155,956
Total Net Assets	**$155,956**
Total Liabilities and Net Assets	**$508,836**

Saint Thomas Midtown Hospital
Statement of Operations
For The Twleve Months Ending June 30, 2013

GROSS PATIENT SERVICE REVENUE:	
Total Inpatient Routine Revenue	$186,890,944
Inpatient Ancillary Revenue	675,142,728
Outpatient Revenue	468,817,146
Total Gross Patient Service Revenue	**$1,330,850,818**
REVENUE DEDUCTIONS:	
Charity Care	$36,116,714
Medicare Deductions	368,981,452
Medicaid Deductions	116,988,500
Blue Cross Deductions	201,685,812
HMO/PPO Deductions	149,401,101
Bad Debts Deductions	21,307,796
Other Revenue and Contract Deductions	47,508,815
Total Revenue Deductions	**$941,990,191**
Net Patient Service Revenue	**$388,860,627**
OTHER REVENUE:	
Other Revenue	$25,243,386
Gain on Sale of Assets	17,597
Income from Unconsolidated Entities	2,560,494
Total Other Revenue	**$27,821,477**
Total Operating Revenue	**$416,682,104**
OPERATING EXPENSES:	
Salaries and Wages	$102,255,051
Employee Benefits	25,852,775
Purchased Services	33,851,801
Professional Fees	8,701,462
Supplies	78,180,091
Insurance	1,517,727
Interest	8,523,868
Income Tax	(32,702)
Depreciation	14,232,321
Amortization	2,394,436
Other Operating Expenses	104,283,074
Total Operating Expenses	**$379,759,903**
Income (Loss) From Recurring Operations	36,922,201
Recurring Op Inc before Non-reucrring Items	36,922,201
Total Impair Write-Dwn, Restruct, NonRec	796,167
Income (Loss) from Operations	**$36,126,034**
NONOPERATING GAINS (LOSSES):	
Other NonOperating Activity	(53,348)
Total NonOperating Gains (Losses), Net	**($53,348)**
Income(Loss) Before Oth NonOper. Items	**$36,072,686**
Net Income (Loss)	**$36,072,686**

Tab 15

Attachment C
Economic Feasibility - 10

Audited Financials

Consolidated Financial Statements and Supplementary Information

Ascension Health Alliance
Years Ended June 30, 2013 and 2012
With Reports of Independent Auditors

Ascension Health Alliance

Consolidated Financial Statements
and Supplementary Information

Years Ended June 30, 2013 and 2012

Contents

Ernst & Young LLP
The Plaza in Clayton Suite 1300
190 Carondelet Plaza
St. Louis, Missouri 63105-3434
Tel: +1 314 290 1000
Fax: +1 314 290 1882
www.ey.com

Report of Independent Auditors

The Board of Directors
Ascension Health Alliance

We have audited the accompanying consolidated financial statements of Ascension Health Alliance, which comprise the consolidated balance sheets as of June 30, 2013 and 2012, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Ascension Health Alliance at June 30, 2013 and 2012, and the consolidated results of their operations and their cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Adoption of ASU No. 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowances for Doubtful Accounts for Certain Health Care Entities*

As discussed in Note 2 to the consolidated financial statements, Ascension Health Alliance changed the presentation of the provision for bad debts as a result of adopting the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update No. 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowances for Doubtful Accounts for Certain Health Care Entities*, effective July 1, 2012. Our opinion is not modified with respect to this matter.

Ernst & Young LLP

September 18, 2013

Ascension Health Alliance

Consolidated Balance Sheets
(Dollars in Thousands)

	June 30, 2013	2012
Assets		
Current assets:		
Cash and cash equivalents	$ **754,622**	$ 306,469
Short-term investments	**113,955**	216,914
Accounts receivable, less allowance for doubtful accounts ($1,351,660 and $1,113,255 at June 30, 2013 and 2012, respectively)	**2,361,809**	1,927,222
Inventories	**309,074**	218,598
Due from brokers *(see Notes 4 and 5)*	**178,380**	789,271
Estimated third-party payor settlements	**119,379**	159,871
Other *(see Notes 4 and 5)*	**1,035,026**	752,348
Total current assets	**4,872,245**	4,370,693
Long-term investments *(see Notes 4 and 5)*	**14,164,185**	10,468,457
Property and equipment, net	**8,546,873**	6,473,918
Other assets:		
Investment in unconsolidated entities	**628,772**	943,747
Capitalized software costs, net	**728,613**	642,596
Other	**1,106,683**	876,483
Total other assets	**2,464,068**	2,462,826
Total assets	**$ 30,047,371**	$ 23,775,894

	June 30, 2013	2012
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	$ **90,442**	$ 45,363
Long-term debt subject to short-term remarketing arrangements*	**1,187,125**	1,094,425
Accounts payable and accrued liabilities	**2,348,401**	1,979,160
Estimated third-party payor settlements	**456,314**	457,030
Due to brokers *(see Notes 4 and 5)*	**493,420**	880,613
Current portion of self-insurance liabilities	**210,115**	206,057
Other *(see Notes 4 and 5)*	**644,084**	435,805
Total current liabilities	**5,429,901**	5,098,453
Noncurrent liabilities:		
Long-term debt (senior and subordinated)	**5,278,866**	3,655,406
Self-insurance liabilities	**553,706**	518,995
Pension and other postretirement liabilities	**554,368**	492,366
Other *(see Notes 4 and 5)*	**1,099,362**	1,087,782
Total noncurrent liabilities	**7,486,302**	5,754,549
Total liabilities	**12,916,203**	10,853,002
Net assets:		
Unrestricted:		
Controlling interest	**14,986,302**	11,836,414
Noncontrolling interests	**1,592,356**	647,236
Unrestricted net assets	**16,578,658**	12,483,650
Temporarily restricted	**377,555**	336,027
Permanently restricted	**174,955**	103,215
Total net assets	**17,131,168**	12,922,892
Total liabilities and net assets	$ **30,047,371**	$ 23,775,894

*Consists of variable rate demand bonds with put options that may be exercised at the option of the bondholders, with stated repayment installments through 2047, as well as certain serial mode bonds with scheduled remarketing/mandatory tender dates occurring prior to June 30, 2014. In the event that bonds are not remarketed upon the exercise of put options or the scheduled mandatory tenders, management would utilize other sources to access the necessary liquidity. Potential sources include liquidating investments, drawing upon the $1 billion line of credit, and issuing commercial paper. The commercial paper program is supported by the $1 billion line of credit.

The accompanying notes are an integral part of the consolidated financial statements.

Ascension Health Alliance

Consolidated Statements of Operations and Changes in Net Assets

(Dollars in Thousands)

	Year Ended June 30, 2013	2012
Operating revenue:		
Net patient service revenue	$ 16,912,410	$ 15,297,559
Less provision for doubtful accounts	1,172,863	972,171
Net patient service revenue, less provision for doubtful accounts	15,739,547	14,325,388
Other revenue	1,357,663	967,252
Total operating revenue	17,097,210	15,292,640
Operating expenses:		
Salaries and wages	7,247,681	6,544,753
Employee benefits	1,581,587	1,426,722
Purchased services	1,030,574	734,396
Professional fees	1,128,880	1,021,582
Supplies	2,427,714	2,260,901
Insurance	115,521	100,834
Interest	150,877	131,310
Depreciation and amortization	755,305	662,362
Other	2,185,015	1,782,172
Total operating expenses before impairment, restructuring, and nonrecurring (losses) gains, net	16,623,154	14,665,032
Income from operations before self-insurance trust fund investment return and impairment, restructuring and nonrecurring (losses) gains, net	474,056	627,608
Self-insurance trust fund investment return	34,985	17,197
Impairment, restructuring, and nonrecurring (losses) gains, net	(111,786)	286,046
Income from operations	397,255	930,851
Nonoperating gains (losses):		
Investment return	737,057	(135,605)
Loss on extinguishment of debt	(4,079)	(2,813)
Gain (loss) on interest rate swaps	61,202	(74,846)
Income from unconsolidated entities	8,544	8,802
Contributions from business combinations, net	2,021,963	326,333
Other	(77,269)	(69,221)
Total nonoperating gains, net	2,747,418	52,650
Excess of revenues and gains over expenses and losses	3,144,673	983,501
Less noncontrolling interests	131,184	13,154
Excess of revenues and gains over expenses and losses attributable to controlling interest	3,013,489	970,347

Continued on next page.

Ascension Health Alliance

Consolidated Statements of Operations and Changes in Net Assets (continued)

(Dollars in Thousands)

	Year Ended June 30, 2013	2012
Unrestricted net assets, controlling interest:		
Excess of revenues and gains over expenses and losses	$ 3,013,489	$ 970,347
Transfers to sponsors and other affiliates, net	(10,962)	(15,189)
Contributed net assets	(1,050)	(400)
Net assets released from restrictions for property acquisitions	67,418	68,892
Pension and other postretirement liability adjustments	77,011	(439,662)
Change in unconsolidated entities' net assets	23,295	(15,890)
Other	4,624	9,206
Increase in unrestricted net assets, controlling interest, before loss from discontinued operations	3,173,825	577,304
Loss from discontinued operations	(23,937)	(73,521)
Increase in unrestricted net assets, controlling interest	3,149,888	503,783
Unrestricted net assets, noncontrolling interests:		
Excess of revenues and gains over expenses and losses	131,184	13,154
Distributions of capital	(829,989)	(575,618)
Contributions of capital	1,579,187	1,166,961
Contributions from business combinations	64,738	–
Increase in unrestricted net assets, noncontrolling interests	945,120	604,497
Temporarily restricted net assets, controlling interest:		
Contributions and grants	89,220	100,880
Investment return	17,232	(638)
Net assets released from restrictions	(110,213)	(104,028)
Contributions from business combinations	44,201	14,764
Other	1,088	(6,514)
Increase in temporarily restricted net assets, controlling interest	41,528	4,464
Permanently restricted net assets, controlling interest:		
Contributions	2,664	5,082
Investment return	1,598	(242)
Contributions from business combinations	67,846	1,573
Other	(368)	(2,642)
Increase in permanently restricted net assets, controlling interest	71,740	3,771
Increase in net assets	4,208,276	1,116,515
Net assets, beginning of year	12,922,892	11,806,377
Net assets, end of year	$ 17,131,168	$ 12,922,892

The accompanying notes are an integral part of the consolidated financial statements.

Ascension Health Alliance

Consolidated Statements of Cash Flows
(Dollars in Thousands)

	Year Ended June 30, 2013	2012
Operating activities		
Increase in net assets	$ **4,208,276**	$ 1,116,515
Adjustments to reconcile increase in net assets to net cash provided by (used in) operating activities:		
Depreciation and amortization	**755,305**	662,362
Amortization of bond premiums	**(13,948)**	(10,663)
Loss on extinguishment of debt	**4,079**	2,813
Provision for doubtful accounts	**1,177,889**	972,171
Pension and other postretirement liability adjustments	**(77,011)**	439,662
Contributed net assets	**1,050**	400
Contributions from business combinations	**(1,742,900)**	(305,162)
Interest, dividends, and net (gains) losses on investments	**(790,871)**	119,288
Change in market value of interest rate swaps	**(61,349)**	77,568
Deferred gain on interest rate swaps	**(303)**	(303)
Gain on sale of assets, net	**(2,986)**	(6,749)
Impairment and nonrecurring expenses	**17,259**	45,956
Contribution of noncontrolling interest in CHIMCO Alpha Fund, LLC	**–**	(440,015)
Transfers to sponsor and other affiliates, net	**10,962**	15,189
Restricted contributions, investment return, and other	**(99,133)**	(117,621)
Other restricted activity	**17,610**	(6,280)
Nonoperating depreciation expense	**317**	308
(Increase) decrease in:		
Short-term investments	**212,560**	35,298
Accounts receivable	**(1,173,962)**	(1,138,644)
Inventories and other current assets	**(205,051)**	244,426
Due from brokers	**610,891**	(83,976)
Investments classified as trading	**(959,834)**	(983,483)
Other assets	**(182,272)**	(11,759)
Increase (decrease) in:		
Accounts payable and accrued liabilities	**(21,721)**	48,504
Estimated third-party payor settlements, net	**29,225**	28,192
Due to brokers	**(387,193)**	(277,720)
Other current liabilities	**92,673**	(288,178)
Self-insurance liabilities	**(15,342)**	(45,390)
Other noncurrent liabilities	**(154,292)**	(351,740)
Net cash provided by (used in) continuing operating activities	**1,249,928**	(259,031)
Net cash (used in) provided by and adjustments to reconcile change in assets for discontinued operations	**(11,301)**	111,046
Net cash provided by (used in) operating activities	**1,238,627**	(147,985)

Continued on next page.

Ascension Health Alliance

Consolidated Statements of Cash Flows (continued)
(Dollars in Thousands)

	Year Ended June 30, 2013	2012
Investing activities		
Property, equipment, and capitalized software additions, net	$ **(901,286)**	$ (840,553)
Proceeds from sale of property and equipment	**26,321**	2,029
Net cash used in investing activities	**(874,965)**	(838,524)
Financing activities		
Issuance of long-term debt	**1,228,995**	1,832,269
Repayment of long-term debt	**(1,236,472)**	(1,779,632)
Decrease in assets under bond indenture agreements	**20,577**	17,513
Transfers to sponsors and other affiliates, net	**(27,742)**	(2,639)
Restricted contributions, investment return, and other	**99,133**	117,621
Net cash provided by financing activities	**84,491**	185,132
Net increase (decrease) in cash and cash equivalents	**448,153**	(801,377)
Cash and cash equivalents at beginning of year	**306,469**	1,107,846
Cash and cash equivalents at end of year	$ **754,622**	$ 306,469

The accompanying notes are an integral part of the consolidated financial statements.

1. Organization and Mission

Organizational Structure

Ascension Health Alliance is a Missouri nonprofit corporation formed on September 13, 2011. Ascension Health Alliance is the sole corporate member and parent organization of Ascension Health, a Catholic national health system consisting primarily of nonprofit corporations that own and operate local healthcare facilities, or Health Ministries, located in 23 of the United States and the District of Columbia.

In addition to serving as the sole corporate member of Ascension Health, Ascension Health Alliance serves as the member or shareholder of various other subsidiaries, including Ascension Health Global Mission; Ascension Health Insurance, Ltd. (AHIL); Ascension Health Resource and Supply Management Group, LLC (The Resource Group); Clinical Holdings Corporation; Catholic Healthcare Investment Management Company (CHIMCO); CHIMCO Alpha Fund, LLC; Ascension Health Ventures, LLC; Ascension Health Leadership Academy, LLC; Ascension Health – IS, Inc. (AHIS); AHV Holding Company, LLC; and AH Holdings, LLC. Ascension Health Alliance and its member organizations are referred to collectively as the System.

Sponsorship

Ascension Health Alliance is sponsored by Ascension Health Ministries, a Public Juridic Person. The Participating Entities of Ascension Health Ministries are the Daughters of Charity of St. Vincent de Paul in the United States, St. Louise Province; the Congregation of St. Joseph; the Congregation of the Sisters of St. Joseph of Carondelet; the Congregation of Alexian Brothers of the Immaculate Conception Province, Inc. – American Province; and the Sisters of the Sorrowful Mother of the Third Order of St. Francis of Assisi – US/Caribbean Province. As more fully described in the Organizational Changes note, Marian Health System, which was previously sponsored by the Sisters of the Sorrowful Mother of the Third Order of St. Francis of Assisi – US/Caribbean Province, became part of Ascension Health on April 1, 2013. In addition, Alexian Brothers Health System, which was previously sponsored by the Congregation of Alexian Brothers of the Immaculate Conception Province, Inc. – American Province, became part of Ascension Health on January 1, 2012.

1. Organization and Mission (continued)

Mission

The System directs its governance and management activities toward strong, vibrant, Catholic Health Ministries united in service and healing, and dedicates its resources to spiritually centered care which sustains and improves the health of the individuals and communities it serves. In accordance with the System's mission of service to those persons living in poverty and other vulnerable persons, each Health Ministry accepts patients regardless of their ability to pay. The System uses four categories to identify the resources utilized for the care of persons living in poverty and community benefit programs:

- Traditional charity care includes the cost of services provided to persons who cannot afford healthcare because of inadequate resources and/or who are uninsured or underinsured.

- Unpaid cost of public programs, excluding Medicare, represents the unpaid cost of services provided to persons covered by public programs for persons living in poverty and other vulnerable persons.

- Cost of other programs for persons living in poverty and other vulnerable persons includes unreimbursed costs of programs intentionally designed to serve the persons living in poverty and other vulnerable persons of the community, including substance abusers, the homeless, victims of child abuse, and persons with acquired immune deficiency syndrome.

- Community benefit consists of the unreimbursed costs of community benefit programs and services for the general community, not solely for the persons living in poverty, including health promotion and education, health clinics and screenings, and medical research.

Discounts are provided to all uninsured patients, including those with the means to pay. Discounts provided to those patients who did not qualify for assistance under charity care guidelines are not included in the cost of providing care of persons living in poverty and community benefit programs. The cost of providing care to persons living in poverty and community benefit programs is estimated by reducing charges forgone by a factor derived from the ratio of each entity's total operating expenses to the entity's billed charges for patient care.

(Dollars in Thousands)

1. Organization and Mission (continued)

Certain costs such as graduate medical education and certain other activities are excluded from total operating expenses for purposes of this computation.

The amount of traditional charity care provided, determined on the basis of cost, was $524,605 and $466,916 for the years ended June 30, 2013 and 2012, respectively. The amount of unpaid cost of public programs, cost of other programs for persons living in poverty and other vulnerable persons, and community benefit cost is reported in the accompanying supplementary information.

2. Significant Accounting Policies

Principles of Consolidation

All corporations and other entities for which operating control is exercised by the System or one of its member corporations are consolidated, and all significant inter-entity transactions have been eliminated in consolidation. Investments in entities where the System does not have operating control are recorded under the equity or cost method of accounting. Income from unconsolidated entities is included in consolidated excess of revenues and gains over expenses and losses in the accompanying Consolidated Statements of Operations and Changes in Net Assets as follows:

	Year Ended June 30, 2013	2012
Other revenue	**$ 105,173**	$ 81,329
Nonoperating gains, net	**8,544**	8,802

Use of Estimates

Management has made estimates and assumptions that affect the reported amounts of certain assets, liabilities, revenues, and expenses. Actual results could differ from those estimates.

2. Significant Accounting Policies (continued)

Fair Value of Financial Instruments

Carrying values of financial instruments classified as current assets and current liabilities approximate fair value. The fair values of other financial instruments are disclosed in the Fair Value Measurements note.

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and interest-bearing deposits with original maturities of three months or less.

Short-Term Investments

Short-term investments consist of investments with original maturities exceeding three months and up to one year.

Inventories

Inventories, consisting primarily of medical supplies and pharmaceuticals, are stated at the lower of cost or market value using first-in, first-out (FIFO) or a methodology that closely approximates FIFO.

Long-Term Investments and Investment Return

Investments, excluding investments in unconsolidated entities, are measured at fair value, are classified as trading securities, and include pooled short-term investment funds; U.S. government, state, municipal and agency obligations; corporate and foreign fixed income securities; asset-backed securities; and equity securities. Investments also include alternative investments and other investments which are valued based on the net asset value of the investments, as further discussed in the Fair Value Measurements note. Investments also include derivatives held by the Alpha Fund, also measured at fair value, as discussed in the Pooled Investment Fund note.

(Dollars in Thousands)

2. Significant Accounting Policies (continued)

Long-term investments include assets limited as to use of approximately $1,313,000 and $916,000, at June 30, 2013 and 2012, respectively, comprised primarily of investments placed in trust and held by captive insurance companies for the payment of self-insured claims and investments which are limited as to use, as designated by donors.

Purchases and sales of investments are accounted for on a trade-date basis. Investment returns consist of dividends, interest, and gains and losses. The cost of substantially all securities sold is based on the average cost method. Investment returns on investments, excluding returns of self-insurance trust funds, are reported as nonoperating gains (losses) in the Consolidated Statements of Operations and Changes in Net Assets, unless the return is restricted by donor or law. Investment returns of self-insurance trust funds are reported as a separate component of income from operations in the Consolidated Statements of Operations and Changes in Net Assets.

Property and Equipment

Property and equipment are stated at cost or, if donated, at fair market value at the date of the gift. A summary of property and equipment at June 30, 2013 and 2012, is as follows:

	June 30, 2013	2012
Land and improvements	**$ 870,810**	$ 653,848
Building and equipment	**14,756,936**	12,917,263
	15,627,746	13,571,111
Less accumulated depreciation	**7,567,936**	7,378,499
	8,059,810	6,192,612
Construction-in-progress	**487,063**	281,306
Total property and equipment, net	**$ 8,546,873**	$ 6,473,918

Depreciation is determined on a straight-line basis over the estimated useful lives of the related assets. Depreciation expense in 2013 and 2012 was $640,232 and $570,198, respectively.

Several capital projects have remaining construction and related equipment purchase commitments of approximately $294,000.

(Dollars in Thousands)

2. Significant Accounting Policies (continued)

Intangible Assets

Intangible assets primarily consist of goodwill and capitalized computer software costs, including internally developed software. Costs incurred in the development and installation of internal use software are expensed or capitalized depending on whether they are incurred in the preliminary project stage, application development stage, or post-implementation stage.

Intangible assets are included in the Consolidated Balance Sheets as presented in the table that follows. Capitalized software costs in the table below include software in progress of $99,048 and $362,336 at June 30, 2013 and 2012, respectively:

	June 30, 2013	2012
Capitalized software costs	**$ 1,423,556**	$ 1,210,729
Less accumulated amortization	**694,943**	568,133
Capitalized software costs, net	**728,613**	642,596
Goodwill	**130,306**	123,707
Other, net	**71,439**	26,205
Intangible assets included in other assets	**201,745**	149,912
Total intangible assets, net	**$ 930,358**	$ 792,508

Intangible assets whose lives are indefinite, primarily goodwill, are not amortized and are evaluated for impairment at least annually, while intangible assets with definite lives, primarily capitalized computer software costs, are amortized over their expected useful lives. Amortization expense for these intangible assets in 2013 and 2012 was $113,126 and $89,704, respectively.

2. Significant Accounting Policies (continued)

During the year ended June 30, 2010, the System began a significant multi-year, System-wide enterprise resource planning project, including information technology and process standardization (Symphony), which is expected to continue through fiscal year 2016. The project is anticipated to result in a transition to a common software product for various finance, information technology, procurement, and human resources management processes, including standardization of those processes throughout the System. Capitalized costs of Symphony were approximately $301,000 and $279,000 at June 30, 2013 and 2012, respectively, and are included in capitalized software costs in the preceding table. Certain costs of this project were also expensed. Beginning September 1, 2012, the software associated with Symphony was considered substantially complete and ready for its intended use and is amortized on a straight-line basis over its expected useful life. Accumulated amortization of Symphony was $25,000 at June 30, 2013. See the Impairment, Restructuring, and Nonrecurring Gains (Losses) discussion below for additional information about costs associated with Symphony.

Noncontrolling Interests

The consolidated financial statements include all assets, liabilities, revenues, and expenses of entities that are controlled by the System and therefore consolidated. Noncontrolling interests in the Consolidated Balance Sheets represent the portion of net assets owned by entities outside the System, for those entities in which the System's ownership interest is less than 100%.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those assets whose use by the System has been limited by donors to a specific time period or purpose. Permanently restricted net assets consist of gifts with corpus values that have been restricted by donors to be maintained in perpetuity, which include endowment funds. Temporarily restricted net assets and earnings on permanently restricted net assets, including earnings on endowment funds, are used in accordance with the donors' wishes, primarily to purchase equipment and to provide charity care and other health and educational services. Contributions with donor-imposed restrictions that are met in the same reporting period are reported as unrestricted.

Temporarily and permanently restricted net assets consist solely of controlling interests of the System.

2. Significant Accounting Policies (continued)

Performance Indicator

The performance indicator is the excess of revenues and gains over expenses and losses. Changes in unrestricted net assets that are excluded from the performance indicator primarily include pension and other postretirement liability adjustments, transfers to or from sponsors and other affiliates, net assets released from restrictions for property acquisitions, change in unconsolidated entities' net assets, cumulative effect of a change in accounting principle, discontinued operations, and contributions received of property and equipment.

Operating and Nonoperating Activities

The System's primary mission is to meet the healthcare needs in its market areas through a broad range of general and specialized healthcare services, including inpatient acute care, outpatient services, long-term care, and other healthcare services. Activities directly associated with the furtherance of this purpose are considered to be operating activities. Other activities that result in gains or losses peripheral to the System's primary mission are considered to be nonoperating.

Net Patient Service Revenue, Accounts Receivable, and Allowance for Doubtful Accounts

Net patient service revenue is reported at the estimated realizable amounts from patients, third-party payors, and others for services provided and includes estimated retroactive adjustments under reimbursement agreements with third-party payors. Revenue under certain third-party payor agreements is subject to audit, retroactive adjustments, and significant regulatory actions. Provisions for third-party payor settlements and adjustments are estimated in the period the related services are provided and adjusted in future periods as additional information becomes available and as final settlements are determined.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. As a result, there is at least a possibility that recorded estimates will change by a material amount in the near term. Adjustments to revenue related to prior periods increased net patient service revenue by $48,997 and $146,535 for the years ended June 30, 2013 and 2012, respectively.

(Dollars in Thousands)

2. Significant Accounting Policies (continued)

The percentage of net patient service revenue, less provision for doubtful accounts earned by payor for the years ended June 30, 2013 and 2012, is as follows:

	June 30,	
	2013	**2012**
Medicare	**37%**	38%
Medicaid	**11**	11
Third-party payors	**44**	41
Self-pay	**8**	10
	100%	100%

The System grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor arrangements. Significant concentrations of accounts receivable, less allowance for doubtful accounts, at June 30, 2013 and 2012, are as follows:

	June 30,	
	2013	**2012**
Medicare	**22%**	20%
Medicaid	**8**	10
Third-party payors	**43**	44
Self-pay	**27**	26
	100%	100%

The provision for doubtful accounts is based upon management's assessment of expected net collections considering economic conditions, historical experience, trends in healthcare coverage, and other collection indicators. Periodically throughout the year, management assesses the adequacy of the allowance for doubtful accounts based upon historical write-off experience by payor category, including those amounts not covered by insurance. The results of this review are then used to make any modifications to the provision for doubtful accounts to establish an appropriate allowance for doubtful accounts. After satisfaction of amounts due from insurance and reasonable efforts to collect from the patient have been exhausted, the System follows established guidelines for placing certain past-due patient balances with collection agencies, subject to the terms of certain restrictions on collection efforts as determined by the System.

2. Significant Accounting Policies (continued)

Accounts receivable are written off after collection efforts have been followed in accordance with the System's policies. See Adoption of New Accounting Standards section for change in accounting presentation of provision for doubtful accounts in the accompanying Consolidated Statements of Operations and Changes in Net Assets.

The methodology for determining the allowance for doubtful accounts and related write-offs on uninsured patient accounts has remained consistent with the prior year. The System has not experienced material changes in write-off trends and has not materially changed its charity care policy since June 30, 2012.

Impairment, Restructuring, and Nonrecurring Gains (Losses)

Long-lived assets are reviewed for impairment whenever events or business conditions indicate the carrying amount of such assets may not be fully recoverable. Initial assessments of recoverability are based on estimates of undiscounted future net cash flows associated with an asset or group of assets. Where impairment is indicated, the carrying amount of these long-lived assets is reduced to fair value based on future discounted net cash flows or other estimates of fair value.

Nonrecurring expenses associated with Symphony include project management and process re-engineering costs, amortization expense for those Health Ministries not yet on Symphony, as well as costs to establish a shared service center and develop a business intelligence data warehouse. Costs associated with product deployment are recorded as nonrecurring gains (losses), and costs associated with product support are recorded as recurring operating expenses.

During the year ended June 30, 2013, the System recorded total impairment, restructuring, and nonrecurring losses, net of $111,786. This amount was comprised primarily of $116,386 of nonrecurring expenses associated with Symphony, one-time termination benefits and other restructuring expenses of $61,677, and impairment and other nonrecurring expenses of $6,040, partially offset by pension curtailment gains of $72,317, as discussed in Retirement Plans note.

During the year ended June 30, 2012, the System recorded total impairment, restructuring and nonrecurring gains, net of $286,046. This amount was comprised primarily of pension curtailment gains of $402,402, as discussed in the Retirement Plans note, partially offset by long-lived asset impairments and restructuring charges of $60,761 and $55,595 of nonrecurring expenses associated with Symphony.

2. Significant Accounting Policies (continued)

Amortization

Bond issuance costs, discounts, and premiums are amortized over the term of the bonds using a method approximating the effective interest method.

Capitalized software, including internally developed software, is amortized on a straight-line basis over the expected useful life of the software.

Income Taxes

The member healthcare entities of the System are primarily tax-exempt organizations under Internal Revenue Code Section 501(c)(3) or Section 501(c)(2), and their related income is exempt from federal income tax under Section 501(a).

Regulatory Compliance

Various federal and state agencies have initiated investigations regarding reimbursement claimed by certain members of the System. The investigations are in various stages of discovery, and the ultimate resolution of these matters, including the liabilities, if any, cannot be readily determined; however, in the opinion of management, the results of the investigations will not have a material adverse impact on the consolidated financial statements of the System.

Reclassifications

Certain reclassifications were made to the 2012 accompanying consolidated financial statements to conform to the 2013 presentation.

2. Significant Accounting Policies (continued)

Adoption of New Accounting Standards

In July 2011, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities.* This accounting standards update requires healthcare entities that recognize significant amounts of patient service revenue at the time services are rendered to present the provision for doubtful accounts related to patient service revenue adjacent to patient service revenue in the Consolidated Statement of Operations and Changes in Net Assets rather than as an operating expense. Additional disclosures relating to sources of patient service revenue and the allowance for doubtful accounts are also required. This new guidance is effective for fiscal years and interim periods within those fiscal years beginning after December 15, 2011.

The System recognizes patient service revenue at the time services are rendered, even though the patient's ability to pay may not be completely assessed at that time. The System adopted this guidance as of July 1, 2012, and retrospectively applied the presentation requirements to all periods presented. Based on an assessment at the reporting entity level, the adoption of this guidance resulted in the reclassification of the System's provision for doubtful accounts for the year ended June 30, 2012, decreasing total operating revenue and total operating expenses before impairment, restructuring, and nonrecurring losses, net by $972,171.

Subsequent Events

The System evaluates the impact of subsequent events, which are events that occur after the Consolidated Balance Sheet date but before the consolidated financial statements are issued, for potential recognition in the consolidated financial statements as of the Consolidated Balance Sheet date. For the year ended June 30, 2013, the System evaluated subsequent events through September 18, 2013, representing the date on which the accompanying audited consolidated financial statements were issued. During this period, there were no material subsequent events that required recognition or disclosure in the accompanying consolidated financial statements.

3. Organizational Changes

Business Combinations

Marian Health System

Effective April 1, 2013, Ascension Health, a subsidiary of the System, became the sole corporate member, through a non-cash business combination transaction, of three regional health systems that formerly comprised Marian Health System, Inc. (Marian Health System): Via Christi Health, Inc. (Via Christi Health), based in Wichita, Kansas; Ministry Health Care, Inc. (Ministry Health Care), based in Milwaukee, Wisconsin; and St. John Health System, Inc. (St. John Health), based in Tulsa, Oklahoma (collectively, the Marian Systems). Prior to this transaction, Marian Health System was the sole corporate member of Ministry Health Care and St. John Health, while Ascension Health and Marian Health System were the two corporate members of Via Christi Health.

Prior to April 1, 2013, the System accounted for its 50% interest in Via Christi Health under the equity method of accounting. The System's investment in Via Christi Health at March 31, 2013 and June 30, 2012, was $545,018 and $493,105, respectively, which amounts were reported in the Consolidated Balance Sheets at those dates in investment in unconsolidated entities. Of these amounts, $28,101 at March 31, 2013, and $30,321 at June 30, 2012, represented the difference between the amount at which the System's investment in Via Christi Health was carried and its interest in the underlying net assets of Via Christi Health, related to the excess of fair value of Via Christi Health property and equipment and long-term debt over their carrying values at the date the System received its interest in Via Christi Health. Via Christi Health's total assets and total liabilities were $1,706,258 and $712,757 at June 30, 2012.

For the year ended June 30, 2013, the System's excess of revenues and gains over expenses and losses included $34,141, representing the System's share of Via Christi Health's excess of revenues over expenses prior to the business combination transaction on April 1, 2013. The System's investment in Via Christi Health of $545,018 at March 31, 2013, was derecognized on April 1, 2013, in conjunction with the accounting for the business combination transaction.

(Dollars in Thousands)

3. Organizational Changes (continued)

Preliminary fair value adjustments for the business combination have been recorded in the accompanying consolidated financial statements as of June 30, 2013. The valuation of net assets is expected to be completed during fiscal 2014. The following table summarizes the April 1, 2013, fair values of the Marian Systems' net assets, by major type.

Net working capital	$ 557,274
Intangible assets, including capitalized software	135,819
Property and equipment	1,950,739
Assets limited as to use	1,126,259
Investments and other long-term assets	1,125,652
Noncurrent liabilities assumed	(2,144,948)
Subtotal	2,750,795
Less: March 31, 2013 Investment in Via Christi Health	(545,018)
Fair value of net assets	$ 2,205,777

The fair value of net assets of $2,205,777 in the preceding table was recognized in the Consolidated Statement of Operations and Changes in Net Assets for the year ended June 30, 2013, as a nonoperating contribution from business combinations of $2,028,992; contributions of temporarily and permanently restricted net assets of $44,201 and $67,846, respectively; and contributions of noncontrolling interests of $64,738.

For the three months ended June 30, 2013, the System recognized revenues of the Marian Systems of $1,049,259, and an excess of revenues and gains over expenses and losses of the Marian Systems of $56,670, of which $55,542 was attributable to controlling interest, with the remaining attributable to noncontrolling interests. Additionally, for the three months ended June 30, 2013, the System recognized an increase in unrestricted net assets – controlling interests, excluding the excess of revenues and gains over expenses and losses of $56,670 above, of $53,801; an increase in unrestricted net assets – noncontrolling interests of $823; an increase in temporarily restricted net assets of $915; and a decrease in permanently restricted net assets of $56.

(Dollars in Thousands)

3. Organizational Changes (continued)

The following unaudited pro forma financial information presents the combined results of operations of the System and the Marian Systems for the years ended June 30, 2013 and 2012, as though the April 1, 2013, business combination transaction had occurred on July 1, 2011. This pro forma financial information is not necessarily indicative of the results of operations that would have occurred had the System and the Marian Systems constituted a single entity during those periods, nor is it necessarily indicative of future operating results.

	Year Ended June 30, 2013	2012
Total operating revenue	**$ 20,566,255**	$ 19,442,796
Excess of revenues and gains over expenses and losses	**1,177,338**	3,129,905
Increase in unrestricted net assets – controlling interest	**1,307,542**	2,678,973
Increase in unrestricted net assets – noncontrolling interests	**879,585**	672,035
Increase in temporarily restricted net assets	**5,856**	47,234
Increase in permanently restricted net assets	**7,945**	70,485

The excess of revenues and gains over expenses and losses and the increase in unrestricted net assets – controlling interest for the year ended June 30, 2012, in the table above include the nonoperating contribution from business combination of $2,028,992 reflected in the Consolidated Statement of Operations and Changes in Net Assets for the year ended June 30, 2013, to reflect the April 1, 2013, business combination as if it had occurred on July 1, 2011. The pro forma excess of revenues and gains over expenses and losses above includes certain adjustments attributable to the April 1, 2013, business combination transaction.

In addition, the increases in unrestricted net assets – controlling interest, temporarily restricted net assets, and permanently restricted net assets for the year ended June 30, 2012, in the table above include the contributions from business combinations reflected in the contributions of noncontrolling interests and temporarily and permanently restricted net assets of $64,738, $44,201, and $67,846, respectively. The preceding amounts are also reflected in the Consolidated Statement of Operations and Changes in Net Assets for the year ended June 30, 2013, to reflect the April 1, 2013, business combination as if it had occurred on July 1, 2011.

3. Organizational Changes (continued)

Alexian Brothers Health System

Effective January 1, 2012, Ascension Health, a subsidiary of the System, became sole corporate member of Alexian Brothers Health System (Alexian Brothers), a Catholic healthcare system that operates acute and specialty care hospitals, ambulatory care clinics, physician practices, and senior living facilities in Illinois, Missouri, Tennessee, and Wisconsin. This transaction resulted in a net increase to unrestricted net assets of $326,333, reflected as contributions from business combinations, net in the Consolidated Statement of Operations and Changes in Net Assets during the year ended June 30, 2012. Furthermore, this addition resulted in a contribution of restricted net assets of $16,337, included in other changes in net assets in the Consolidated Statement of Operations and Changes in Net Assets for the year ended June 30, 2012.

Divestitures and Discontinued Operations

On May 1, 2013, the System entered into a definitive agreement with HCA Midwest Health System to sell St. Joseph and St. Mary's Medical Centers and other Carondelet Health subsidiaries in Kansas City, Missouri (Carondelet Health – Kansas City). This transaction is expected to close in fiscal year 2014. The operations of Carondelet Health – Kansas City are reflected in the System's consolidated financial statements as discontinued operations. The assets and liabilities of Carondelet Health – Kansas City are classified as held for sale in other assets and other liabilities, respectively, in the System's consolidated financial statements.

Effective October 1, 2011, Seton Health System, Inc. (Seton Health) in Troy, New York, separated from the System and became part of a newly formed nonprofit healthcare organization that operates in the state of New York. The operations of Seton Health are reflected in the System's consolidated financial statements as discontinued operations.

The System reported a decrease in net assets from discontinued operations of $23,937 for the year ended June 30, 2013, representing the decrease in net assets related to the separation of Carondelet Health – Kansas City and the deficit of revenues over expenses for previously discontinued lines of business in Michigan. These entities had recorded operating revenues totaling $303,430 during the period that they were operational during the year ended June 30, 2013.

3. Organizational Changes (continued)

The System reported a decrease in net assets from discontinued operations of $73,521 for the year ended June 30, 2012, representing the decrease of net assets related to the separation of Seton Health, the deficit of revenues over expenses for Carondelet Health – Kansas City and for previously discontinued lines of business in Michigan. These entities had recorded operating revenues totaling $354,486 during the period that they were operational during the year ended June 30, 2012.

4. Pooled Investment Fund

Prior to April 2012, the System held a significant portion of its investments in the Ascension Legacy Portfolio (formerly the Health System Depository, or HSD), an investment pool of funds in which the System and a limited number of nonprofit healthcare providers participated. In April 2012, a significant portion of the assets in the Ascension Legacy Portfolio was transferred to the CHIMCO Alpha Fund, LLC (Alpha Fund), a limited liability company organized in the state of Delaware.

At June 30, 2013 and 2012, a significant portion of the System's investments consists of the System's interest in the Alpha Fund. Certain System assets continue to be held through the Ascension Legacy Portfolio, and subsequent to April 2012, the Ascension Legacy Portfolio no longer holds assets for unrelated entities. Additional System investments include those held and managed by the Health Ministries' consolidated foundations.

The Alpha Fund includes the investment interests of the System and other Alpha Fund members. CHIMCO manages and serves as the manager and primary investment advisor of the Alpha Fund, overseeing the investment strategies offered to the Alpha Fund's members. The System began consolidating the Alpha Fund in April 2012.

The portion of the Alpha Fund's net assets representing interests held by entities other than the System are reflected in noncontrolling interests in the Consolidated Balance Sheets, which amount to $1,450,580 and $589,493 at June 30, 2013 and 2012, respectively.

The consolidation of the Alpha Fund by the System in April 2012 resulted in an increase of net assets of $440,015, representing the noncontrolling interests of the Alpha Fund as of the date investments were transferred into the Alpha Fund.

4. Pooled Investment Fund (continued)

Prior to April 2012, CHIMCO, a wholly owned subsidiary of the System, managed the investment portfolio of the System held in the Ascension Legacy Portfolio. CHIMCO provides expertise in the areas of asset allocation, selection and monitoring of outside investment managers, and risk management. The System did not consolidate the Ascension Legacy Portfolio prior to April 2012. Accordingly, the System's investments recorded in the consolidated financial statements consisted only of the System's pro rata share of the Ascension Legacy Portfolio's investments held for participants prior to April 2012.

The Alpha Fund invests in a diversified portfolio of investments including alternative investments, such as real asset funds, hedge funds, private equity funds, commodity funds, and private credit funds. Collectively, these funds have liquidity terms ranging from daily to annual with notice periods ranging from 1 to 180 days. Due to redemption restrictions, investments in certain of these funds, whose fair value was $920,761 at June 30, 2013, cannot currently be redeemed. However, the potential for the Alpha Fund to sell its interest in these funds in a secondary market prior to the end of the fund term does exist.

The Alpha Fund's investments in certain alternative investment funds also include contractual commitments to provide capital contributions during the investment period, which is typically five years and can extend to the end of the fund term. During these contractual periods, investment managers may require the Alpha Fund to invest in accordance with the terms of the agreement. Commitments not funded during the investment period will expire and remain unfunded. As of June 30, 2013, contractual agreements of the Alpha Fund expire between July 2013 and April 2019. The remaining unfunded capital commitments of the Alpha Fund total approximately $1,140,000 for 76 individual funds as of June 30, 2013. Due to the uncertainty surrounding whether the contractual commitments will require funding during the contractual period, future minimum payments to meet these commitments cannot be reasonably estimated. These committed amounts are expected to be primarily satisfied by the liquidation of existing investments in the Alpha Fund.

In the normal course of operations and within established Alpha Fund guidelines, the Alpha Fund may enter into various exchange-traded and over-the-counter derivative contracts for trading purposes, including futures, option, and forward contracts as well as warrants and swaps. These instruments are used primarily to adjust the portfolio duration, restructure term structure exposure, change sector exposure, and arbitrage market inefficiencies. See the Fair Value Measurements note for a discussion of how fair value for the Alpha Fund's derivatives is determined.

4. Pooled Investment Fund (continued)

At June 30, 2013 and 2012, the notional value of Alpha Fund derivatives outstanding was approximately $2,126,000 and $2,071,000, respectively. The fair value of Alpha Fund derivatives in an asset position was $35,404 and $71,936 at June 30, 2013 and 2012, respectively, while the fair value of Alpha Fund derivatives in a liability position was $84,249 and $36,266 at June 30, 2013 and 2012, respectively. These derivatives are included in long-term investments in the Consolidated Balance Sheets at June 30, 2013 and 2012.

The Alpha Fund also participates in a securities lending program, whereby a portion of the Alpha Fund's investments are loaned to selected established brokerage firms in return for cash and securities from the brokers as collateral for the investments loaned, usually on a short-term basis. The fair value of collateral held by the Alpha Fund associated with such lending agreements amounts to approximately $394,000 and $320,000 at June 30, 2013 and 2012, respectively, and is included in other current assets in the Consolidated Balance Sheets, while the liability associated with the obligation to repay such collateral is also approximately $394,000 and $320,000 at June 30, 2013 and 2012, respectively, and is included in other current liabilities in the Consolidated Balance Sheets. In addition, the Alpha Fund has liabilities for investments sold, not yet purchased, representing obligations of the Alpha Fund to purchase investments in the market at prevailing prices. The fair value of this Alpha Fund liability is approximately $7,000 and $160,000 at June 30, 2013 and 2012, respectively, and is included in other noncurrent liabilities in the Consolidated Balance Sheets.

Due from brokers and due to brokers on the Consolidated Balance Sheets at June 30, 2013 and 2012, represent the Alpha Fund's positions and amounts due from or to various brokers, primarily amounts for security transactions not yet settled, and cash held by brokers for securities sold, not yet purchased.

(Dollars in Thousands)

5. Cash and Investments

The System's cash and investments are reported in the June 30, 2013 and 2012, Consolidated Balance Sheets as presented in the table that follows. Total cash and investments, net, includes both the System's membership interest in the Alpha Fund and the noncontrolling interests held by other Alpha Fund members. System unrestricted cash and investments, net, represent the System's cash and investments excluding the noncontrolling interests held by other Alpha Fund members and assets limited as to use.

	June 30, 2013	2012
Cash and cash equivalents	**$ 754,622**	$ 306,469
Short-term investments	**113,955**	216,914
Long-term investments	**14,164,185**	10,468,457
Subtotal	**15,032,762**	10,991,840
Other Alpha Fund and Ascension Legacy Portfolio assets and liabilities:		
In other current assets	**459,050**	360,999
In other long-term assets	**2,785**	2,924
In accounts payable and other accrued liabilities	**(5,680)**	(12,779)
In other current liabilities	**(394,763)**	(322,873)
In other noncurrent liabilities	**(6,622)**	(157,073)
Due to brokers, net	**(315,040)**	(91,342)
Total cash and investments, net	**14,772,492**	10,771,696
Less noncontrolling interests of Alpha Fund	**1,450,580**	589,493
System cash and investments, including assets limited as to use	**13,321,912**	10,182,203
Less assets limited as to use:		
Under bond indenture agreement	**33,955**	16,966
Self-insurance trust funds	**728,621**	683,937
Temporarily or permanently restricted	**564,168**	363,482
Total assets limited as to use	**1,326,744**	1,064,385
System unrestricted cash and investments, net	**$ 11,995,168**	$ 9,117,818

(Dollars in Thousands)

5. Cash and Investments (continued)

At June 30, 2013 and 2012, the composition of cash and cash equivalents, short-term investments and long-term investments, which include certain assets limited as to use, is summarized as follows.

	June 30, 2013	2012
Cash and cash equivalents and short-term investments	**$ 1,113,823**	$ 498,902
Pooled short-term investment funds	**311,027**	416,087
U.S. government, state, municipal, and agency obligations	**3,447,500**	3,271,474
Corporate and foreign fixed income securities	**1,664,001**	980,322
Asset-backed securities	**1,196,168**	1,057,735
Equity securities	**2,695,483**	1,574,188
Alternative investments and other investments:		
Private equity and real estate funds	**809,341**	594,466
Hedge funds	**2,860,776**	1,887,407
Commodities funds and other investments	**934,643**	711,259
Total alternative investments and other investments	**4,604,760**	3,193,132
Total cash and cash equivalents, short-term investments, and long-term investments	**$ 15,032,762**	$ 10,991,840

Net investments under CHIMCO management and held in the Ascension Legacy Portfolio at March 31, 2012, yet not included in the Alpha Fund or the Ascension Legacy Portfolio while still managed by CHIMCO at April 1, 2012, were approximately $1,820,000. As of June 30, 2013 and 2012, the System's membership interest in the Alpha Fund totaled $11,251,590 and $8,840,551, respectively. As of June 30, 2013 and 2012, the noncontrolling interest (see Note 2) in the Alpha Fund, representing interests held by entities other than the System, totaled $1,450,580 and $589,493, respectively.

Investment return recognized by the System for the years ended June 30, 2013 and 2012, is summarized in the following table. Total investment return includes the System's return in the Ascension Legacy Portfolio and the investment return of the Alpha Fund. System investment return represents the System's total investment return, net of the investment return earned by the noncontrolling interests of other Alpha Fund members.

(Dollars in Thousands)

5. Cash and Investments (continued)

	Year Ended June 30, 2013	2012
Unrestricted investment return in Ascension Legacy Portfolio	$ –	$ 63,965
Interest and dividends	**170,034**	51,453
Net gains (losses) on investments reported at fair value	**602,008**	(233,826)
Restricted investment return and unrealized gains (losses), net	**18,830**	(880)
Total investment return	**790,872**	(119,288)
Less return earned by noncontrolling interests of Alpha Fund	**106,039**	(9,278)
System investment return	**$ 684,833**	$ (110,010)

6. Fair Value Measurements

The System categorizes, for disclosure purposes, assets and liabilities measured at fair value in the consolidated financial statements based upon whether the inputs used to determine their fair values are observable or unobservable. Observable inputs are inputs that are based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about pricing the asset or liability, based on the best information available in the circumstances.

In certain cases, the inputs used to measure fair value may fall into different levels of the fair value hierarchy. In such cases, an asset's or liability's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement of the asset or liability. The System's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

The System follows the three-level fair value hierarchy to categorize these assets and liabilities recognized at fair value at each reporting period, which prioritizes the inputs used to measure such fair values. Level inputs are defined as follows:

Level 1 – Quoted prices (unadjusted) that are readily available in active markets or exchanges for identical assets or liabilities on the reporting date.

6. Fair Value Measurements (continued)

Level 2 – Inputs other than quoted market prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. Level 2 pricing inputs include prices quoted for similar assets and liabilities in active markets or exchanges or prices quoted for identical or similar assets and liabilities in markets that are not active. If the asset or liability has a specified (contractual) term, a Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Significant pricing inputs that are unobservable for the asset or liability, including assets or liabilities for which there is little, if any market activity for such asset or liability. Inputs to the determination of fair value for Level 3 assets and liabilities require management judgment and estimation.

There were no significant transfers between Levels 1 and 2 during the years ended June 30, 2013 and 2012.

As of June 30, 2013 and 2012, the assets and liabilities listed in the fair value hierarchy tables below use the following valuation techniques and inputs:

Cash and cash equivalents and short-term investments

Cash and cash equivalents and certain short-term investments include certificates of deposit, whose fair value is based on cost plus accrued interest. Significant observable inputs include security cost, maturity, and relevant short-term interest rates. Other short-term investments designated as Level 2 investments primarily consist of commercial paper, whose fair value is based on the income approach. Significant observable inputs include security cost, maturity, credit rating, interest rate, and par value.

Pooled short-term investment fund

The fair value of pooled fund investments is based on cost plus guaranteed, annuity contract-based interest rates. Significant unobservable inputs to the guaranteed rate include the fair value and average duration of the portfolio of investments underlying the annuity contract, the contract value, and the annualized weighted-average yield to maturity of the underlying investment portfolio.

6. Fair Value Measurements (continued)

U. S. government, state, municipal, and agency obligations

The fair value of investments in U.S. government, state, municipal, and agency obligations is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark constant maturity curves and spreads.

Corporate and foreign fixed income securities

The fair value of investments in U.S. and international corporate bonds, including commingled funds that invest primarily in such bonds, and foreign government bonds is primarily determined using techniques that are consistent with the market approach. Significant observable inputs include benchmark yields, reported trades, observable broker-dealer quotes, issuer spreads, and security specific characteristics, such as early redemption options.

Asset-backed securities

The fair value of U.S. agency and corporate asset-backed securities is primarily determined using techniques consistent with the income approach. Significant observable inputs include prepayment speeds and spreads, benchmark yield curves, volatility measures, and quotes.

Equity securities

The fair value of investments in U.S. and international equity securities is primarily determined using techniques consistent with the income approach. The values for underlying investments are fair value estimates determined by external fund managers based on quoted market prices, operating results, balance sheet stability, growth, dividend, dividend yield, and other business and market sector fundamentals.

6. Fair Value Measurements (continued)

Alternative investments and other investments

Alternative investments consist of private equity, hedge funds, private equity funds, commodity funds, and real estate partnerships. The fair value of private equity is primarily determined using techniques consistent with both the market and income approaches, based on the System's estimates and assumptions in the absence of observable market data. The market approach considers comparable company, comparable transaction, and company-specific information, including but not limited to restrictions on disposition, subsequent purchases of the same or similar securities by other investors, pending mergers or acquisitions, and current financial position and operating results. The income approach considers the projected operating performance of the portfolio company.

The fair value of hedge funds, private equity funds, commodity funds, and real estate partnerships is primarily determined using net asset values, which approximate fair value, as determined by an external fund manager based on quoted market prices, operating results, balance sheet stability, growth, and other business and market sector fundamentals.

Other investments include derivative assets and derivative liabilities of the Alpha Fund, whose fair value is primarily determined using techniques consistent with the market approach. Significant observable inputs to valuation models include interest rates, Treasury yields, volatilities, credit spreads, maturity, and recovery rates.

Securities lending collateral

The fair value of collateral received under the Alpha Fund's securities lending program is valued using the calculated net asset value for the commingled fund in which the collateral is invested. The underlying investments in the commingled fund are valued using techniques consistent with the market approach, which uses significant observable market inputs such as available trade, quotes, benchmark curves, sector groupings, and matrix pricing.

6. Fair Value Measurements (continued)

Benefit plan assets

The fair value of benefit plan assets is based on original investment into a guaranteed pooled fund, plus guaranteed, annuity contract-based interest rates. Significant unobservable inputs to the guaranteed rate include the fair value and average duration of the portfolio of investments underlying annuity contract, the contract value, and the annualized weighted-average yield to maturity of the underlying investment portfolio.

Interest rate swap assets and liabilities

The fair value of interest rate swaps is primarily determined using techniques consistent with the market approach. Significant observable inputs to valuation models include interest rates, Treasury yields, volatilities, credit spreads, maturity, and recovery rates.

Investments sold, not yet purchased

The fair value of investments sold, not yet purchased is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark, constant maturity curves, and spreads.

(Dollars in Thousands)

6. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2013, for all financial assets and liabilities measured at fair value on a recurring basis in the System's consolidated financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2013				
Cash and cash equivalents	$ 618,129	$ 14,277	$ –	$ 632,406
Short-term investments	21,821	45,258	238	67,317
Pooled short-term investment funds	311,027	–	–	311,027
U.S. government, state, municipal, and agency obligations	–	3,441,671	5,829	3,447,500
Corporate and foreign fixed income securities	–	1,272,714	391,287	1,664,001
Asset-backed securities	–	1,079,135	117,033	1,196,168
Equity securities	2,656,950	36,370	2,163	2,695,483
Alternative investments and other investments:				
Private equity and real estate funds	529	3,752	799,414	803,695
Hedge funds	–	–	2,857,114	2,857,114
Commodities funds and other investments	5,762	(6,061)	831,182	830,883
Assets not at fair value				527,168
Cash and investments				$ 15,032,762
Securities lending collateral, in other current assets	$ –	$ 394,310	$ –	$ 394,310
Benefit plan assets, in other noncurrent assets	225,755	–	37,505	263,260
Interest rate swaps, in other noncurrent assets	–	76,650	–	76,650
Investments sold, not yet purchased, in other noncurrent liabilities	–	6,622	–	6,622
Interest rate swaps, included in other noncurrent liabilities	–	194,546	–	194,546

(Dollars in Thousands)

6. Fair Value Measurements (continued)

For the year ended June 30, 2013, the changes in the fair value of the assets and liabilities measured using significant unobservable inputs (Level 3) consisted of the following.

	Short-Term Investments	U.S. Government, State, Municipal, and Agency Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity and Real Estate Funds	Hedge Funds	Commodities Funds and Other Investments	Benefit Plan Assets
June 30, 2013									
Beginning balance	$ –	$ 7,437	$ 120,418	$ 15,297	$ 13,118	$ 593,753	$ 1,887,407	$ 615,813	$ 36,882
Total realized and unrealized gains (losses):									
Included in income from operations	–	16	242	10	1,489	–	123	(45)	–
Included in nonoperating gains (losses)		445	1,059	(227)	170	83,975	220,887	80,222	49
Included in changes in net assets	3	–	–	–	–	–	293	27	–
Purchases	–	169	328,980	122,703	718	188,085	981,414	401,957	47,644
Settlements	–	–	–	–	–	(25)	–	–	(279)
Sales	–	(2,238)	(58,928)	(17,883)	(13,372)	(66,836)	(232,198)	(266,889)	(44,655)
Transfers into Level 3	235	–	2,962	–	40	927	3,271	139	13,376
Transfers out of Level 3	–	–	(3,446)	(2,867)	–	(465)	(4,083)	(42)	(15,512)
Ending balance	$ 238	$ 5,829	$ 391,287	$ 117,033	$ 2,163	$ 799,414	$ 2,857,114	$ 831,182	$ 37,505

The basis for recognizing and valuing transfers into or out of Level 3, in the Level 3 rollforward, is as of the beginning of the period in which the transfers occur.

(Dollars in Thousands)

6. Fair Value Measurements (continued)

The following table summarizes fair value measurements, by level, at June 30, 2012, for all financial assets and liabilities measured at fair value on a recurring basis in the System's consolidated financial statements:

	Level 1	Level 2	Level 3	Total
June 30, 2012				
Cash and cash equivalents	$ 78,301	$ 3,419	$ –	$ 81,720
Short-term investments	14,567	79,321	–	93,888
Pooled short-term investment funds	416,087	–	–	416,087
U.S. government, state, municipal, and agency obligations	–	3,264,037	7,437	3,271,474
Corporate and foreign fixed income securities	–	859,904	120,418	980,322
Asset-backed securities	–	1,042,438	15,297	1,057,735
Equity securities	1,546,579	14,491	13,118	1,574,188
Alternative investments and other investments:				
Private equity and real estate funds	–	–	593,753	593,753
Hedge funds	–	–	1,887,407	1,887,407
Commodities funds and other investments	8,699	3,327	615,813	627,839
Assets not at fair value				407,427
Cash and investments				$ 10,991,840
Securities lending collateral, in other current assets	$ –	$ 321,937	$ –	$ 321,937
Benefit plan assets, in other noncurrent assets	134,705	–	36,882	171,587
Interest rate swaps, in other noncurrent assets	–	94,082	–	94,082
Investments sold, not yet purchased, in other noncurrent liabilities	–	157,073	–	157,073
Interest rate swaps, included in other noncurrent liabilities	–	252,413	–	252,413

(Dollars in Thousands)

6. Fair Value Measurements (continued)

For the year ended June 30, 2012, the changes in the fair value of the assets and liabilities measured using significant unobservable inputs (Level 3) consisted of the following. Level 3 investments of the Alpha Fund are included in transfers in the table below.

	U.S. Government, State, Municipal, and Agency Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity and Real Estate Funds	Hedge Funds	Commodities Funds and Other Investments	Benefit Plan Assets
June 30, 2012								
Beginning balance	$ 442	$ 5,024	$ 1,924	$ 15,515	$ 71,768	$ 11,667	$ 2,731	$ 31,706
Total realized and unrealized gains (losses):								
Included in income from operations	21	192	(7)	886	–	45	(436)	–
Included in nonoperating gains (losses)	6	904	(149)	(69)	(6,814)	(15,149)	(12,031)	–
Included in changes in net assets	–	–	–	–	64	1,233	(7)	20
Purchases	–	77,943	2,919	–	64,537	154,740	238,895	8,701
Settlements	–	–	–	–	–	–	–	(91)
Issuances	–	–	–	–	–	–	–	35
Sales	–	(57,768)	(2,700)	(3,588)	(9,215)	(5,187)	(76,098)	(5,373)
Transfers into Level 3	6,968	94,201	15,012	374	473,413	1,740,058	462,759	2,649
Transfers out of Level 3	–	(78)	(1,702)	–	–	–	–	(765)
Ending balance	$ 7,437	$ 120,418	$ 15,297	$ 13,118	$ 593,753	$ 1,887,407	$ 615,813	$ 36,882

The basis for recognizing and valuing transfers into or out of Level 3, in the Level 3 rollforward, is as of the beginning of the period in which the transfers occur.

(Dollars in Thousands)

7. Long-Term Debt

Long-term debt at June 30, 2013 and 2012, is comprised of the following and is presented in accordance with the specific master trust indenture to which the debt relates. As further discussed below, certain portions of long-term debt are secured under the Alexian Brothers Health System Master Trust Indenture; the Mercy Regional Health Center, Inc. Master Trust Indenture; The Howard Young Medical Center, Inc. Master Trust Indenture; the St. John Health System Master Trust Indenture; and the Ministry Health Care Master Trust Indenture.

	June 30, 2013	2012
Tax-exempt hospital revenue bonds – secured under Ascension Health Alliance Senior Credit Group Master Trust Indenture:		
Variable rate demand bonds, subject to a put provision that provides for a cumulative 7-month notice and remarketing period, payable through November 2047; interest (0.12% to 0.15% at June 30, 2013) tied to a market index plus a spread	$ **408,605**	$ 308,605
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2039; interest (0.06% to 0.07% at June 30, 2013) set at prevailing market rates	**225,665**	225,665
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2033; interest (0.06% to 0.07% at June 30, 2013) set at prevailing market rates, swapped to fixed rates of 5.454% and 5.544%, respectively, through maturity	**307,300**	307,300
Indexed put bonds subject to weekly rate resets based on a taxable index, payable through November 2046; interest (2.095% at June 30, 2013) swapped to a variable rate tied to a tax-exempt market index plus a spread through November 2016	**153,800**	153,800
Fixed rate put bonds (converted from an indexed put bond mode based on a taxable index in May 2009) payable through November 2046; interest (4.10% at June 30, 2013) swapped to a variable rate tied to a market index plus a spread through November 2016	**153,690**	153,690
Fixed rate serial and term bonds payable in installments through November 2051; interest at 2.00% to 5.25%	**1,207,490**	1,308,105
Fixed rate serial and term bonds payable in installments through November 2039; interest at 5.00% swapped to variable rates over the life of the bonds	**587,360**	587,360
Fixed rate serial mode bonds payable through 2047 with purchase dates ranging from June 2014 through June 2021; interest at 0.90% to 5.00% through the purchase dates	**1,224,750**	904,185

(Dollars in Thousands)

7. Long-Term Debt (continued)

	June 30, 2013	2012
Tax-exempt hospital revenue bonds – unsecured under Ascension Health Alliance Subordinate Master Trust Indenture:		
Variable rate demand bonds, subject to a 7-day put provision, payable through November 2027; interest (0.06% at June 30, 2013) set at prevailing market rates	$ **56,060**	$ 56,060
Fixed rate serial mode bonds payable through 2027 with purchase dates through November 2019; interest at 1.625%, swapped to variable mode through the purchase dates	**49,810**	49,810
Fixed rate serial mode bonds payable through 2027 with purchase dates through May 2018; interest at 0.55% to 5.00%	**396,705**	396,705
Taxable bonds – secured under Ascension Health Alliance Senior Credit Group Master Trust Indenture:		
Taxable fixed rate term bonds payable in installments through November 2053; interest at 4.847%	**425,000**	–
Total hospital revenue bonds under Senior Master Trust Indenture and Subordinate Master Trust Indenture	**5,196,235**	4,451,285
Tax-exempt hospital revenue bonds – secured under Alexian Brothers Health System Master Trust Indenture:		
Fixed rate term bonds payable in installments through February 2038; interest at 3.50% to 5.50%	**157,000**	161,565
Total hospital revenue bonds under the Alexian Brothers Health System Master Trust Indenture	**157,000**	161,565
Tax-exempt hospital revenue bonds – secured under Mercy Regional Health Center, Inc. Master Trust Indenture:		
Fixed rate term bonds payable in installments through November 2029; interest at 2.00% to 5.00%	**25,060**	–
Total hospital revenue bonds under the Mercy Regional Health Center, Inc. Master Trust Indenture	**25,060**	–
Tax-exempt hospital revenue bonds – secured under The Howard Young Medical Center, Inc. Master Trust Indenture:		
Fixed rate term bonds payable in installments through August 2030; interest at 3.00% to 5.00%	**20,040**	–
Total hospital revenue bonds under The Howard Young Medical Center, Inc. Master Trust Indenture	**20,040**	–

(Dollars in Thousands)

7. Long-Term Debt (continued)

	June 30, 2013	2012
Tax-exempt hospital revenue bonds – secured under St. John Health System Master Trust Indenture:		
Fixed rate term bonds payable in installments through February 2042; interest at 4.00% to 5.00%	**$ 414,500**	$ –
Total hospital revenue bonds under the St. John Health System Master Trust Indenture	**414,500**	–
Tax-exempt hospital revenue bonds – secured under Ministry Health Care Master Trust Indenture:		
Fixed rate term bonds payable in installments through August 2035; interest at 2.50% to 5.50%	**368,260**	–
Total hospital revenue bonds under the Ministry Health Care Master Trust Indenture	**368,260**	–
Total hospital revenue bonds under the Ascension Health Alliance Senior Master Trust Indenture; Ascension Health Alliance Subordinate Master Trust Indenture; the Alexian Brothers Health System Master Trust Indenture; the Mercy Regional Health Center, Inc. Master Trust Indenture; The Howard Young Medical Center, Inc. Master Trust Indenture; St. John Health System Master Trust Indenture; and Ministry Health Care Master Trust Indenture	**6,181,095**	4,612,850
Other debt:		
Obligations under capital leases	**42,979**	33,221
Other	**113,823**	37,936
	6,337,897	4,684,007
Unamortized premium, net	**218,536**	111,187
Less current portion	**(90,442)**	(45,363)
Less long-term debt subject to short-term remarketing arrangements	**(1,187,125)**	(1,094,425)
Long-term debt, less current portion and long-term debt subject to short-term remarketing arrangements	**$ 5,278,866**	$ 3,655,406

(Dollars in Thousands)

7. Long-Term Debt (continued)

	June 30, 2013	2012
Ascension Health Alliance Senior Master Trust Indenture long-term debt obligations, including unamortized premium, net	**$ 3,579,334**	$ 2,919,702
Ascension Health Alliance Subordinate Master Trust Indenture long-term debt obligations, including unamortized premium, net	**511,009**	515,278
Alexian Brothers Health System Master Trust Indenture long-term debt obligations, including unamortized premium, net	**162,594**	167,257
Mercy Health Regional Center, Inc. Master Trust Indenture long-term debt obligations, including unamortized premium, net	**27,258**	–
The Howard Young Medical Center, Inc. Master Trust Indenture long-term debt obligations, including unamortized premium, net	**20,933**	–
St. John Health System Master Trust Indenture long-term debt obligations, including unamortized premium, net	**437,503**	–
Ministry Health Care Master Trust Indenture long-term debt obligations, including unamortized premium, net	**394,781**	–
Other	**145,454**	53,169
Long-term debt, less current portion, and long-term debt subject to short-term remarketing arrangements	**$ 5,278,866**	$ 3,655,406

Scheduled principal repayments of long-term debt, considering obligations subject to short-term remarketing as due according to their long-term amortization schedule, as of June 30, 2013, are as follows:

	Ascension Health Alliance MTIs	Alexian Brothers Health System MTI	Mercy Regional Health Center, Inc. MTI	The Howard Young Medical Center, Inc. MTI	St. John Health System MTI	Ministry Health Care MTI	Other Debt	Total
Year ending June 30:								
2014	$ 57,135	$ 3,290	$ 1,020	$ 855	$ 6,950	$ 9,845	$ 11,230	$ 90,325
2015	59,835	340	1,045	875	7,305	11,185	10,168	90,753
2016	50,130	7,485	1,080	910	7,680	11,665	6,393	85,343
2017	65,945	13,130	1,125	945	8,070	12,185	19,878	121,278
2018	69,045	15,655	1,175	975	6,890	12,890	6,422	113,052
Thereafter	4,894,145	117,100	19,615	15,480	377,605	310,490	102,711	5,837,146
Total	$ 5,196,235	$ 157,000	$ 25,060	$ 20,040	$ 414,500	$ 368,260	$ 156,802	$ 6,337,897

7. Long-Term Debt (continued)

The carrying amounts of variable rate bonds and other notes payable approximate fair value. The fair values of the unsecured fixed rate serial and term bonds are obtained from independent public valuation services. The fair value of fixed rate serial and term bonds, including the component of variable rate demand bonds subject to long-term fixed interest rates, approximates carrying value at June 30, 2013 and 2012. During the years ended June 30, 2013 and 2012, interest paid was approximately $170,000 and $144,000, respectively. Capitalized interest was approximately $5,400 and $2,000 for the years ended June 30, 2013 and 2012, respectively.

Certain members of the System formed the Ascension Health Alliance Credit Group (Senior Credit Group). Each Senior Credit Group member is identified as either a senior obligated group member, a senior designated affiliate, or a senior limited designated affiliate. Senior obligated group members are jointly and severally liable under a Senior Master Trust Indenture (Senior MTI) to make all payments required with respect to obligations under the Senior MTI and may be entities not controlled directly or indirectly by the System. Senior designated affiliates and senior limited designated affiliates are not obligated to make debt service payments on the obligations under the Senior MTI. The System may cause each senior designated affiliate to transfer such amounts as are necessary to enable the obligated group to comply with the terms of the Senior MTI, including payment of the outstanding obligations. Additionally, each senior limited designated affiliate has an independent limited designated affiliate agreement and promissory note with the System with stipulated repayment terms and conditions, each subject to the governing law of the senior limited designated affiliate's state of incorporation.

Pursuant to a Supplemental Master Indenture dated February 1, 2005, senior obligated group members, which are operating entities, have pledged and assigned to the Master Trustee a security interest in all of their rights, title, and interest in their pledged revenues and proceeds thereof.

A Subordinate Credit Group, which is comprised of subordinate obligated group members, subordinate designated affiliates, and subordinate limited designated affiliates, was created under the Subordinate Master Trust Indenture (Subordinate MTI). The subordinate obligated group members are jointly and severally liable under the Subordinate MTI to make all payments required with respect to obligations under the Subordinate MTI and may be entities not controlled directly or indirectly by the System. Subordinate designated affiliates and subordinate limited designated affiliates are not obligated to make debt service payments on the obligations under the Subordinate MTI. The System may cause each subordinate designated affiliate to

7. Long-Term Debt (continued)

transfer such amounts as are necessary to enable the obligated group members to comply with the terms of the Subordinate MTI, including payment of the outstanding obligations. Additionally, each subordinate limited designated affiliate has an independent subordinate limited designated affiliate agreement and promissory note with the System, with stipulated repayment terms and conditions, each subject to the governing law of the subordinate limited designated affiliate's state of incorporation.

The unsecured variable rate demand bonds of both the Senior and Subordinate Credit Groups, while subject to long-term amortization periods, may be put to the System at the option of the bondholders in connection with certain remarketing dates. To the extent that bondholders may, under the terms of the debt, put their bonds within 12 months after June 30, 2013, the principal amount of such bonds has been classified as a current liability in the accompanying Consolidated Balance Sheets. Management believes the likelihood of a material amount of bonds being put to the System to be remote. However, to address this possibility, management has taken steps to provide various sources of liquidity in the event any bonds would be put, including the line of credit, commercial paper program, and maintaining unrestricted assets as a source of self-liquidity.

On January 1, 2012, Alexian Brothers became part of the System. Subsequently, the System redeemed or refinanced a portion of Alexian Brothers' debt; however, a portion of the bonds previously issued for the benefit of Alexian Brothers remains outstanding (the Alexian Brothers' Bonds). The Alexian Brothers' Bonds continue to be secured by the Alexian Brothers Health System Master Trust Indenture (As Amended and Restated), dated October 1, 1992, between the Members of the Alexian Brothers Health System Obligated Group established under this document and the Alexian Brothers Health System Master Trustee.

On April 1, 2013, Marian Health System joined Ascension Health. Subsequently, the System redeemed or refinanced a portion of the debt of the Marian Systems; however, a portion of the bonds previously issued for the benefit of the Marian Systems remains outstanding. These bonds continue to be secured by the respective Master Trust Indentures, including the Amended and Restated Master Trust Indenture dated October 1, 1999, by and between St. John Health System and the St. John Health Master Trustee; the Master Trust Indenture dated October 1, 1984, by and between Ministry Health Care and the Ministry Health Care Master Trustee; the Master Trust Indenture dated August 15, 1993, between The Howard Young Medical Center, Inc., a subsidiary of Ministry Health Care, and The Howard Young Medical Center, Inc. Master

7. Long-Term Debt (continued)

Trustee; and the Master Trust Indenture dated January 15, 2013, between Mercy Regional Health Center, Inc. (a subsidiary of Via Christi Health) and the Mercy Regional Health Center, Inc. Master Trustee.

In June 2013, the System issued a total of $521,865 of tax-exempt bonds, Series 2013A and 2013B, through the Wisconsin issuing authority. In June 2013, the System also issued a total of $425,000 of taxable bonds, Series 2013A. The proceeds of the bonds, including original issue premium, were used to refinance debt and general corporate purposes.

In May 2012, the System issued a total of $435,370 of tax-exempt bonds, Series 2012A through 2012E, through four different issuing authorities in four different states. The proceeds of the bonds, including original issue premium, were used to reimburse the System for previous capital expenditures.

Due to aggregate financing activity during the fiscal years ended June 30, 2013 and 2012, losses on extinguishment of debt of $4,079 and $2,813, respectively, were recorded, which are included in nonoperating gains (losses) in the accompanying Consolidated Statements of Operations and Changes in Net Assets.

The System is a party to multiple interest rate swap agreements that convert the variable or fixed rates of certain debt issues to fixed or variable rates, respectively. See the Derivative Instruments note for a discussion of these derivatives.

As of June 30, 2013, the Senior Credit Group has a line of credit of $1,000,000 which may be used as a source of funding for unremarketed variable debt (including commercial paper) or for general corporate purposes, towards which bank commitments totaling $1,000,000 extend to November 9, 2014. As of June 30, 2013 and 2012, there were no borrowings under the line of credit.

As of June 30, 2013, the Senior Credit Group has a $75,000 revolving line of credit related to its letters of credit program toward which a bank commitment of $75,000 extends to November 27, 2013. The revolving line of credit may be accessed solely in the form of Letters of Credit issued by the bank for the benefit of the members of the Credit Groups. Of this $75,000 revolving line of credit, letters of credit totaling $46,765 have been issued as of June 30, 2013. No borrowings were outstanding under the letters of credit as of June 30, 2013 and 2012.

(Dollars in Thousands)

8. Derivative Instruments

The System uses interest rate swap agreements to manage interest rate risk associated with its outstanding debt. Interest rate swaps with varying characteristics are outstanding under the Master Trust Indentures of the System, Alexian Brothers, Ministry Health Care, and St. John Health. These swaps have historically been used to effectively convert interest rates on variable rate bonds to fixed rates and rates on fixed rate bonds to variable rates. At June 30, 2013 and 2012, the notional values of outstanding interest rate swaps were as follows:

	June 30, 2013	2012
Ascension Health Alliance MTI	**$ 2,128,757**	$ 2,189,232
Alexian Brothers Health System MTI	**47,220**	55,120
Ministry Health Care MTI	**270,880**	–
St. John Health System MTI	**125,000**	–
Total	**$ 2,571,857**	$ 2,244,352

The System recognizes the fair value of its interest rate swaps in the Consolidated Balance Sheets as assets, recorded in other noncurrent assets, or liabilities, recorded in other noncurrent liabilities, as appropriate. The respective fair values of interest rate swaps in an asset and liability position for the System, Alexian Brothers, Ministry Health Care and St. John Health were as follows:

	June 30, 2013		June 30, 2012	
	Asset	Liability	Asset	Liability
Ascension Health Alliance MTI	**$ 73,846**	**$ 174,413**	$ 94,082	$ 248,511
Alexian Brothers Health System MTI	**–**	**2,685**	–	3,902
Ministry Health Care MTI	**2,804**	**16,492**	–	–
St. John Health System MTI	**–**	**956**	–	–
Total	**$ 76,650**	**$ 194,546**	$ 94,082	$ 252,413

(Dollars in Thousands)

8. Derivative Instruments (continued)

The System's interest rate swap agreements include collateral requirements for each counterparty under such agreements, based upon specific contractual criteria. Collateral requirements are separately calculated for the System, Alexian Brothers, Ministry Health Care, and St. John Health based on the credit ratings of each. In the case of the System, the applicable credit rating is the Senior Credit Group long-term debt credit ratings (Senior Debt Credit Ratings), as obtained from each of two major credit rating agencies. Credit rating and the net liability position of total interest rate swap agreements outstanding with each counterparty determine the amount of collateral to be posted. Collateral and net fair value of interest rate swap agreements with credit-risk-related contingent features at June 30, 2013 and 2012, based upon the respective net liability positions and applicable credit ratings were as follows:

	June 30, 2013		June 30, 2012	
	Net Fair Value	Collateral Posted	Net Fair Value	Collateral Posted
Ascension Health Alliance MTI	**$ (100,567)**	**$ –**	$ (154,429)	$ –
Alexian Brothers Health System MTI	**(2,685)**	**–**	(3,902)	–
Ministry Health Care MTI	**(13,688)**	**23,024**	–	–
St. John Health System MTI	**(956)**	**–**	–	–
Total	**$ (117,896)**	**$ 23,024**	$ (158,331)	$ –

Prior to July 1, 2006, the System designated certain of its interest rate swaps as cash flow hedges, for accounting purposes, and accordingly deferred gains or losses associated with those swaps in net assets. As of June 30, 2013, the deferred net gain associated with these interest rate swaps was $4,357. The portion of this gain that will be reclassified into nonoperating gains (losses) over the next 12 months is immaterial.

Beginning July 1, 2006, the System's previously designated cash flow hedging relationships were de-designated for accounting purposes. Accordingly, all changes in the fair value of interest rate swaps have been recognized in nonoperating gains (losses) in the accompanying Consolidated Statements of Operations and Changes in Net Assets. A net nonoperating loss of $61,349 was recognized for the year ended June 30, 2013, while a net nonoperating loss of $77,568 was recognized for the year ended June 30, 2012.

9. Retirement Plans

Defined-Benefit Plans

Certain System entities participate in defined-benefit pension plans (the System Plans), which are noncontributory, defined-benefit pension plans covering substantially all eligible employees of certain System entities. Benefits are based on each participant's years of service and compensation. All of the System Plans' assets are invested in Trusts, which include the Master Pension Trust (the Trust) and other trusts (the Other Trusts). The System Plans' assets primarily consist of cash and cash equivalents, equity, fixed income funds, and alternative investments. Contributions to the System Plans are based on actuarially determined amounts sufficient to meet the benefits to be paid to participants.

During the years ended June 30, 2013 and 2012, the System approved and communicated to employees a redesign of associate retirement benefits, which affects certain System Plans, as well as provides an enhanced comprehensive defined contribution plan. This redesign resulted in the recognition of curtailment gains of $73,198 and $415,834, for the years ended June 30, 2013 and 2012, respectively, of which, $73,198 and $402,402 was recognized in total impairment, restructuring, and nonrecurring gains for the years ended June 30, 2013 and 2012, respectively. This redesign also resulted in a decrease to the projected benefit obligation and is included in pension and other postretirement liabilities in the Consolidated Balance Sheets.

The assets of the System Plans are available to pay the benefits of eligible employees and retirees of all participating entities. In the event entities participating in the System Plans are unable to fulfill their financial obligations under the System Plans, the other participating entities are obligated to do so.

(Dollars in Thousands)

9. Retirement Plans (continued)

The following table sets forth the combined benefit obligations and assets of the System Plans at June 30, 2013 and 2012, components of net periodic benefit costs for the years then ended, and a reconciliation of the amounts recognized in the accompanying consolidated financial statements.

	Year Ended June 30, 2013	2012
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	**$ 6,437,246**	$ 5,734,449
Service cost	**119,018**	194,906
Interest cost	**289,634**	311,981
Amendments	**(12,792)**	(5,463)
Assumption change	**(363,778)**	873,252
Actuarial (gain) loss	**(28,641)**	1,051
Business combinations	**1,137,270**	131,174
Curtailment	**(74,962)**	(561,854)
Benefits paid	**(301,215)**	(242,250)
Projected benefit obligation at end of year	**7,201,780**	6,437,246
Accumulated benefit obligation at end of year	**7,155,166**	6,341,693
Change in plan assets:		
Fair value of plan assets at beginning of year	**5,992,677**	5,397,593
Actual return on plan assets	**121,715**	711,555
Employer contributions	**54,541**	14,421
Business combinations	**874,666**	111,358
Benefits paid	**(301,215)**	(242,250)
Fair value of plan assets at end of year	**6,742,384**	5,992,677
Net amount recognized at end of year and funded status	**$ (459,396)**	$ (444,569)

The System Plans' funded status as a percentage of the projected benefit obligation at June 30, 2013 and 2012, was 93.6% and 93.1%, respectively. The System Plans' funded status as a percentage of the accumulated benefit obligation at June 30, 2013 and 2012, was 94.2% and 94.5%, respectively.

(Dollars in Thousands)

9. Retirement Plans (continued)

Included in unrestricted net assets at June 30, 2013 and 2012, are the following amounts that have not yet been recognized in net periodic pension cost for the System Plans:

	Year Ended June 30, 2013	2012
Unrecognized prior service credit	$ **(23,080)**	$ (16,230)
Unrecognized actuarial loss	**364,739**	433,352
	$ **341,659**	$ 417,122

Changes in plan assets and benefit obligations recognized in unrestricted net assets for System Plans during 2013 and 2012 include:

	Year Ended June 30, 2013	2012
Current year actuarial (gain) loss	$ **(87,934)**	$ 48,601
Amortization of actuarial loss	**19,725**	350,877
Current year prior service credit	**(12,792)**	(5,463)
Amortization of prior service credit	**5,944**	58,781
	$ **(75,057)**	$ 452,796

	Year Ended June 30, 2013	2012
Components of net periodic benefit cost		
Service cost	$ **119,018**	$ 194,906
Interest cost	**289,634**	311,981
Expected return on plan assets	**(500,497)**	(447,703)
Amortization of prior service credit	**(6,242)**	(10,646)
Amortization of actuarial loss	**53,783**	16,931
Curtailment gain	**(73,198)**	(415,834)
Settlement gain	**(12)**	(111)
Net periodic benefit cost	$ **(117,514)**	$ (350,476)

(Dollars in Thousands)

9. Retirement Plans (continued)

The prior service credit and actuarial loss included in unrestricted net assets and expected to be recognized in net periodic pension cost during the year ending June 30, 2014, are $4,200 and $7,630, respectively.

The assumptions used to determine the benefit obligation and net periodic benefit cost for the System Plans are set forth below:

	June 30,	
	2013	**2012**
Weighted-average discount rate	**4.88%**	4.42%
Weighted-average rate of compensation increase	**3.81%**	4.00%
Weighted-average expected long-term rate of return on plan assets	**8.30%**	8.43%

The System Plans' assets invested in the Trust are invested in a portfolio designed to protect principal and obtain competitive investment returns and long-term investment growth, consistent with actuarial assumptions, with a reasonable and prudent level of risk. Diversification is achieved by allocating to funds and managers that correlate to one of three economic strategies: growth, deflation, and inflation. Growth strategies include U.S. equity, emerging market equity, global equity, international equity, directional hedge funds, private equity, high yield, and private credit. Deflation strategies include core fixed income, absolute return hedge funds, and cash. Inflation strategies include inflation-linked bonds, commodity-related investments, and real assets. The System Plans use multiple investment managers with complementary styles, philosophies, and approaches. In accordance with the System Plans' objectives, derivatives may also be used to gain market exposure in an efficient and timely manner.

(Dollars in Thousands)

9. Retirement Plans (continued)

In accordance with the System Plans' asset diversification targets, as presented in the table that follows, the Trust holds certain alternative investments, consisting of various hedge funds, real asset funds, private equity funds, commodity funds, private credit funds, and certain other private funds. These investments do not have observable market values. As such, each of these investments is valued at net asset value as determined by each fund's investment manager, which approximates fair value. The fair value of the System Plans' alternative investments in the Trust as of June 30, 2013, is reported in the fair value measurement table that follows. Collectively, these funds have liquidity terms ranging from daily to annual with notice periods ranging from 1 to 180 days. Due to redemption restrictions, investments of certain private funds, whose fair value was approximately $665,000 at June 30, 2013, cannot be redeemed. However, the potential for the System Plans to sell their interest in real asset funds and private equity funds in a secondary market prior to the end of the fund term does exist.

The investments in these alternative investment funds may also include contractual commitments to provide capital contributions during the investment period, which is typically five years, and may extend to the end of the fund term. During these contractual periods, investment managers may require the System Plans to invest in accordance with the terms of the agreement. Commitments not funded during the investment period will expire and remain unfunded. As of June 30, 2013, investment periods expire between July 2013 and March 2018. The remaining unfunded capital commitments of the Trust total approximately $525,000 for 57 individual contracts as of June 30, 2013.

The weighted-average asset allocation for the System Plans in the Trust at the end of fiscal 2013 and 2012 and the target allocation for fiscal 2014, by asset category, are as follows:

	Target Allocation	Percentage of Plan Assets at Year-End	
Asset category	**2014**	**2013**	**2012**
Growth	50%	**52%**	49%
Deflation	30	**29**	32
Inflation	20	**19**	19
Total	100%	**100%**	100%

(Dollars in Thousands)

9. Retirement Plans (continued)

The System Plans' assets in the Other Trusts are invested in portfolios designed to best serve the participants of the System Plans' through a long-term investment strategy designed to ensure that funds are available to pay benefits as they become due and to maximize the total return at a prudent level of investment risk. The System Plans' assets invested in the Other Trusts are diversified among various assets classes based upon established investment guidelines.

Asset category	Target Allocation 2014	Percentage of Plan Assets at Year-End 2013	2012
Cash	4%	**6%**	1%
Growth	58	**61**	63
Income	29	**25**	22
Other	9	**8**	14
Total	100%	**100%**	100%

(Dollars in Thousands)

9. Retirement Plans (continued)

The following tables summarize fair value measurements at June 30, 2013 and 2012, by asset class and by level, for the System Plans' assets and liabilities. As also discussed in the Fair Value Measurements note, the System follows the three-level fair value hierarchy to categorize plan assets and liabilities recognized at fair value, which prioritizes the inputs used to measure such fair values. The inputs and valuation techniques discussed in the Fair Value Measurements note also apply to the System Plans' assets and liabilities as presented in the following tables.

	Level 1	Level 2	Level 3	Total
June 30, 2013				
Short-term investments	$ 324,803	$ 20,331	$ –	$ 345,134
Derivatives receivable	1,078	337	21,059	22,474
U.S. government, state, municipal, and agency obligations	–	1,671,493	1,266	1,672,759
Corporate and foreign fixed income securities	25,843	566,812	53,729	646,384
Asset-backed securities	–	226,920	22,838	249,758
Equity securities	1,317,933	18,741	2,936	1,339,610
Alternative investments and other investments:				
Private equity and real estate funds	–	–	747,864	747,864
Hedge funds	34,708	–	1,452,190	1,486,898
Commodities funds and other investments	–	316,971	271,282	588,253
Assets not at fair value				334,875
Total				7,434,009
Derivatives payable	68	300	248,988	249,356
Investments sold, not yet purchased	3,794	(71)	–	3,723
Liabilities not at fair value				438,546
Total				691,625
Fair value of plan assets				$ 6,742,384

(Dollars in Thousands)

9. Retirement Plans (continued)

	Level 1	Level 2	Level 3	Total
June 30, 2012				
Short-term investments	$ 192,025	$ 5,392	$ –	$ 197,417
Derivatives receivable	63,991	92,702	14,229	170,922
U.S. government, state, municipal, and agency obligations	–	2,189,580	1,903	2,191,483
Corporate and foreign fixed income securities	70,238	387,734	28,308	486,280
Asset-backed securities	–	194,201	14,243	208,444
Equity securities	782,558	–	1,514	784,072
Alternative investments and other investments:				
Private equity and real estate funds	–	–	546,165	546,165
Hedge funds	–	–	1,187,124	1,187,124
Commodities funds and other investments	–	–	282,320	282,320
Assets not at fair value				874,681
Total				6,928,908
Derivatives payable	5,849	51,314	6,055	63,218
Investments sold, not yet purchased	–	29,342	–	29,342
Liabilities not at fair value				843,671
Total				936,231
Fair value of plan assets				$ 5,992,677

(Dollars in Thousands)

9. Retirement Plans (continued)

For the years ended June 30, 2013 and 2012, the changes in the fair value of the System Plans' assets measured using significant unobservable inputs (Level 3) consisted of the following:

	Net Derivatives	U.S. Government, State, Municipal, and Agency Obligations	Corporate and Foreign Fixed Income Securities	Asset-Backed Securities	Equity Securities	Private Equity and Real Estate Funds	Hedge Funds	Commodities Funds and Other Investments
June 30, 2013								
Beginning balance	$ 8,174	$ 1,903	$ 28,308	$ 14,243	$ 1,514	$ 546,165	$ 1,187,124	$ 282,320
Acquisitions	–	–	–	–	–	37,048	–	9,994
Total actual return on assets	(154,133)	130	(171)	(89)	5	54,153	147,977	(21,032)
Purchases, issuances, and settlements	(122,486)	(767)	31,994	20,384	1,417	98,174	156,513	–
Transfers into (out of) Level 3	40,516	–	(6,402)	(11,700)	–	12,324	(39,424)	–
Ending balance	$ (227,929)	$ 1,266	$ 53,729	$ 22,838	$ 2,936	$ 747,864	$ 1,452,190	$ 271,282
Actual return on plan assets relating to plan assets still held at June 30, 2013	$ (280,606)	$ 59	$ (2,202)	$ (115)	$ 227	$ 54,968	$ 147,248	$ (21,024)
June 30, 2012								
Beginning balance	$ (208,367)	$ 2,129	$ 19,462	$ 4,427	$ 1,701	$ 376,420	$ 1,011,817	$ 203,246
Acquisitions	–	–	–	–	–	–	30,428	–
Total actual return on assets	167,900	48	1,431	(211)	(196)	25,991	(9,426)	(30,748)
Purchases, issuances, and settlements	48,641	(274)	9,662	10,517	–	143,754	154,305	109,826
Transfers (out of) into Level 3	–	–	(2,247)	(490)	9	–	–	(4)
Ending balance	$ 8,174	$ 1,903	$ 28,308	$ 14,243	$ 1,514	$ 546,165	$ 1,187,124	$ 282,320
Actual return on plan assets relating to plan assets still held at June 30, 2012	$ 9,095	$ 11	$ (820)	$ (477)	$ –	$ 18,389	$ (38,835)	$ (29,356)

The Trust has entered into a series of interest rate swap agreements with a net notional amount of $2,699,100. The combined targeted duration of these swaps and the Trust's fixed income investments approximates the duration of the liabilities of the Trust. Currently, 75% of the dollar duration of the liability is subject to this economic hedge. The purpose of this strategy is to economically hedge the change in the net funded status for a significant portion of the liability that can occur due to changes in interest rates.

(Dollars in Thousands)

9. Retirement Plans (continued)

The expected long-term rate of return on the System Plans' assets is based on historical and projected rates of return for current and planned asset categories in the investment portfolio. Assumed projected rates of return for each asset category were selected after analyzing historical experience and future expectations of the returns and volatility for assets of that category using benchmark rates. Based on the target asset allocation among the asset categories, the overall expected rate of return for the portfolio was developed and adjusted for historical and expected experience of active portfolio management results compared to benchmark returns and for the effect of expenses paid from plan assets.

Information about the expected cash flows for the System Plans follows:

Expected employer contributions 2014	$ 53,090
Expected benefit payments:	
2014	445,000
2015	452,800
2016	464,400
2017	484,000
2018	489,500
2019–2023	2,461,000

The contribution amount above includes amounts paid to Trusts. The benefit payment amounts above reflect the total benefits expected to be paid from Trusts.

Other Postretirement Benefit Plans

In addition to the retirement plan described above, certain Health Ministries sponsor postretirement benefit plans that provide healthcare benefits to qualified retirees who meet certain eligibility requirements. The total benefit obligation of these plans at June 30, 2013 and 2012, is $45,308 and $47,428, respectively. The net obligation included in pension and other postretirement liabilities in the accompanying Consolidated Balance Sheets at June 30, 2013 and 2012, is $6,624 and $12,423, respectively. The change in the plans' assets and benefit obligations recognized in unrestricted net assets during the year ended June 30, 2013, was $2,678.

9. Retirement Plans (continued)

Defined-Contribution Plans

System entities participate in contributory and noncontributory defined-contribution plans covering all eligible associates. There are three primary types of contributions to these plans: employer automatic contributions, employee contributions, and employer matching contributions. Benefits for employer automatic contributions are determined as a percentage of a participant's salary and, for certain entities, increases over specified periods of employee service. These benefits are funded annually, and participants become fully vested over a period of time. Benefits for employer matching contributions are determined as a percentage of an eligible participant's contributions each payroll period. These benefits are funded each payroll period, and participants become fully vested in these employer contributions immediately. Expenses for the defined-contribution plans were $202,838 and $127,134 during 2013 and 2012, respectively.

10. Self-Insurance Programs

Certain System hospitals and other entities participate in pooled risk programs to insure professional and general liability risks and workers' compensation risks to the extent of certain self-insured limits. In addition, various umbrella insurance policies have been purchased to provide coverage in excess of the self-insured limits. The System provides its self-insurance through various trust funds and captive insurance companies. Actuarially determined amounts, discounted at 6% for the System, are contributed to the trust funds and the captive insurance companies to provide for the estimated cost of claims. The loss reserves recorded for estimated self-insured professional, general liability, and workers' compensation claims include estimates of the ultimate costs for both reported claims and claims incurred but not reported, which are discounted at 6% in 2013 and 2012 for the System. Those entities not participating in the self-insured programs are insured under separate policies.

10. Self-Insurance Programs (continued)

Professional and General Liability Programs

Professional and general liability coverage is provided on a claims-made basis through a wholly owned onshore trust and through AHIL.

AHIL has a self-insured retention of $10,000 per occurrence with no aggregate. Excess coverage is provided through AHIL with limits up to $185,000. AHIL retains $5,000 per occurrence and $5,000 annual aggregate for professional liability. AHIL also retains a 20% quota share of the first $25,000 of umbrella excess. The remaining excess coverage is reinsured by commercial carriers.

Sunflower Assurance, Inc. (Sunflower) was acquired when Marian Health System joined the System. Sunflower provides excess coverage with limits up to $75,000 above the primary coverage for Via Christi Health and retains 10% of the first reinsurance layer of $10,000 on a quota share basis. The remaining excess coverage is reinsured by commercial carriers.

Self-insured entities in the states of Indiana, Kansas, and Wisconsin are provided professional liability coverage with limits in compliance with participation in the Patient Compensation Funds. The Patient Compensation Funds apply to claims in excess of the primary self-insured limit.

Included in operating expenses in the accompanying Consolidated Statements of Operations and Changes in Net Assets is professional and general liability expense of $74,887 and $71,687 for the years ended June 30, 2013 and 2012, respectively. Included in current and long-term self-insurance liabilities on the accompanying Consolidated Balance Sheets are professional and general liability loss reserves of $614,913 and $596,381 at June 30, 2013 and 2012, respectively.

AHIL also offers physician professional liability coverage through insurance or reinsurance arrangements to nonemployed physicians practicing at the System's various facilities, primarily in Michigan, Indiana, Kansas, and Illinois. Coverage is offered to physicians with limits ranging from $100 per claim to $1,000 per claim with various aggregate limits.

Edessa Insurance Company Ltd. (Edessa) was acquired as part of the Alexian Brothers business combination, as discussed in the Organizational Changes note. Effective July 1, 2012, the self-insurance programs of Edessa were consolidated into AHIL, and Edessa ceased operations.

(Dollars in Thousands)

10. Self-Insurance Programs (continued)

Workers' Compensation

Workers' compensation coverage is provided on an occurrence basis through a grantor trust. The self-insured trust provides coverage up to $1,000 per occurrence with no aggregate. The trust provides a mechanism for funding the workers' compensation obligations of its members. Workers' compensation coverage for Marian Health System is self-insured or commercially insured up to various limits. Excess insurance against catastrophic loss is obtained through commercial insurers. Premium payments made to the trust are expensed and represent claims reported and claims incurred but not reported.

Included in operating expenses in the accompanying Consolidated Statements of Operations and Changes in Net Assets is workers' compensation expense of $44,395 and $40,256 for the years ended June 30, 2013 and 2012, respectively. Included in current and long-term self-insurance liabilities on the accompanying Consolidated Balance Sheets are workers' compensation loss reserves of $137,825 and $110,657 at June 30, 2013 and 2012, respectively.

11. Lease Commitments

Future minimum payments under noncancelable operating leases with terms of one year or more are as follows:

Year ending June 30:	
2014	$ 211,716
2015	191,235
2016	149,545
2017	121,166
2018	93,215
Thereafter	231,248
Total	$ 998,125

Certain System entities are lessees under operating lease agreements for the use of space in buildings owned by third parties, including medical office buildings (MOBs) and medical and information technology equipment. In addition, certain System entities have subleased space within buildings where the entity has a current operating lease commitment. Certain System entities are also lessors under operating lease agreements, primarily ground leases related to third-party-owned MOBs on land owned by the System entity.

(Dollars in Thousands)

11. Lease Commitments (continued)

The System's future minimum noncancelable payments associated with operating leases where a System entity is the lessee, as well as future minimum noncancelable receipts associated with operating leases where a System entity is the sublessor or lessor, are presented in the table that follows. Future minimum payments and receipts relate to noncancelable leases with terms of one year or more.

	Future Payments Where the System is Lessee	Future Receipts Where the System is Sublessor/ Lessor	Net Future Payments (Receipts)
Year ending June 30:			
2014	$ 211,716	$ 45,749	$ 165,967
2015	191,235	38,072	153,163
2016	149,545	32,591	116,954
2017	121,166	28,075	93,091
2018	93,215	25,289	67,926
Thereafter	231,248	299,907	(68,659)
Total	$ 998,125	$ 469,683	$ 528,442

Rental expense under operating leases amounted to $365,718 and $336,538 in 2013 and 2012, respectively.

12. Contingencies and Commitments

The System is involved in litigation and regulatory investigations arising in the ordinary course of business. Regulatory investigations also occur from time to time. In the opinion of management, after consultation with legal counsel, these matters are expected to be resolved without material adverse effect on the System's Consolidated Balance Sheet.

In March 2013, the System and some of its subsidiaries were named as defendants to litigation surrounding the Church Plan status of its System Plans. The System does not believe that this matter will have a material adverse effect on the System's financial position or results of operations.

(Dollars in Thousands)

12. Contingencies and Commitments (continued)

In September 2010, Ascension Health received a letter from the U.S. Department of Justice (the DOJ) in connection with its nationwide review to determine whether, in certain cases, implantable cardioverter defibrillators were provided to certain Medicare beneficiaries in accordance with national coverage criteria. In connection with this nationwide review, identified System hospitals are reviewing applicable medical records and responding to the DOJ. The DOJ's investigation spans a time frame beginning in 2003 and extending through the present time. Through September 18, 2013, the DOJ has not asserted any claims against any System hospitals. The System continues to fully cooperate with the DOJ in its investigation.

The System enters into agreements with nonemployed physicians that include minimum revenue guarantees. The terms of the guarantees vary. The carrying amounts of the liability for the System's obligation under these guarantees were $44,606 and $26,678 at June 30, 2013 and 2012, respectively, and are included in other current and noncurrent liabilities in the accompanying Consolidated Balance Sheets. The maximum amount of future payments that the System could be required to make under these guarantees is approximately $100,100.

The System entered into agreements with sponsors for support through January 2017. The System's obligation under these agreements totals $49,028 at June 30, 2013, and is included in other current and noncurrent liabilities in the accompanying Consolidated Balance Sheet.

The System entered into Master Service Agreements for information technology services provided by third parties. The maximum amount of future payments that the System could be required to make under these agreements is approximately $201,600.

Guarantees and other commitments represent contingent commitments issued by Ascension Health Alliance Senior and Subordinate Credit Groups, generally to guarantee the performance of an affiliate to a third party in borrowing arrangements such as commercial paper issuances, bond financing, and other transactions. The terms of guarantees are equal to the terms of the related debt, which can be as long as 27 years. The following represents the remaining guarantees and other commitments of the Senior and Subordinate Credit Group at June 30, 2013:

Hospital de la Conceptión 2000 Series A debt guarantee	$	30,185
St. Vincent de Paul Series 2000A debt guarantee		28,300
Other guarantees and commitments		33,937

Supplementary Information

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Report of Independent Auditors on Supplementary Information

The Board of Directors
Ascension Health Alliance

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The Schedule of Net Cost of Providing Care of Persons Living in Poverty and Community Benefit Programs, the Details of Consolidated Balance Sheets, and the Details of Consolidated Statements of Operations and Changes in Net Assets are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Ernst & Young LLP

September 18, 2013

Ascension Health Alliance

Schedule of Net Cost of Providing Care of Persons Living in Poverty and Community Benefit Programs

(Dollars in Thousands)

Years Ended June 30, 2013 and 2012

The net cost of providing care to persons living in poverty and community benefit programs is as follows:

	June 30, 2013	2012
Traditional charity care provided	**$ 524,605**	$ 466,916
Unpaid cost of public programs for persons living in poverty	**488,959**	455,401
Other programs for personal living in poverty and other vulnerable persons	**89,923**	75,724
Community benefit programs	**383,583**	335,436
Care of persons living in poverty and community benefit programs	**$ 1,487,070**	$ 1,333,477

Ascension Health Alliance

Details of Consolidated Balance Sheet
(Dollars in Thousands)

June 30, 2013

	Consolidated Ascension Health Alliance	Consolidated Ascension Health Alliance less Health Ministries Presented	Reclassification	Consolidated Baltimore	Consolidated Birmingham	Consolidated Flint	Consolidated Kalamazoo	Consolidated Lewiston
Assets								
Current assets:								
Cash and cash equivalents	$ 754,622	$ 221,598	$ –	$ 14,826	$ 13,436	$ 5,136	$ 11,691	$ 5,737
Short-term investments	113,955	51,189	–	–	–	500	–	565
Accounts receivable, less allowances for uncollectible accounts ($1,351,660 in 2013)	2,361,809	1,241,572	–	53,294	71,872	48,531	63,725	21,606
Inventories	309,074	149,528	–	7,633	12,292	6,714	8,050	2,875
Due from brokers	178,380	178,380	–	–	–	–	–	–
Estimated third-party payor settlements	119,379	55,731	–	–	8,200	9,321	6,897	–
Other	1,035,026	789,045	–	5,293	13,554	9,805	10,261	1,682
Total current assets	4,872,245	2,687,043	–	81,046	119,354	80,007	100,624	32,465
Long-term investments	14,164,185	9,921,466	3,705,308	15,104	16,508	1,993	21,788	593
Interest in investments held by Ascension Health Alliance	–	–	(3,705,308)	180,235	188,196	188,395	139,959	75,636
Property and equipment, net	8,546,873	3,930,621	–	240,204	354,150	159,567	161,025	39,901
Other assets:								
Investment in unconsolidated entities	628,772	223,985	–	18,717	5,889	14,535	16,876	–
Capitalized software costs, net	728,613	502,282	–	1,162	1,906	9,590	157	2,404
Other	1,106,683	761,482	–	12,830	10,309	14,125	23,144	14,623
Total other assets	2,464,068	1,487,749	–	32,709	18,104	38,250	40,177	17,027
Total assets	$ 30,047,371	$ 18,026,879	$ –	$ 549,298	$ 696,312	$ 468,212	$ 463,573	$ 165,622

Consolidated Milwaukee	Consolidated Ministry	Consolidated Mobile	Consolidated Nashville	Consolidated Saginaw & Tawas	Consolidated Tucson	Consolidated Tulsa	Consolidated Waco	Consolidated Washington D.C.	Consolidated Wichita
$ 4,107	$ 301,544	$ 1,144	$ 12,393	$ 7,949	$ 7,438	$ 30,935	$ 3,583	$ 1,201	$ 111,904
–	24,023	–	253	11,012	5,862	7,916	1,455	–	11,180
89,751	169,137	31,632	138,556	38,787	59,941	129,596	43,103	28,526	132,180
10,542	27,432	6,168	15,816	6,404	10,236	15,766	5,027	2,740	21,851
–	–	–	–	–	–	–	–	–	–
1,243	6,299	3,204	7,637	5,075	1,154	2,906	8,192	1,327	2,193
24,876	55,760	5,225	26,362	8,292	10,171	22,955	1,677	5,439	44,629
130,519	584,195	47,373	201,017	77,519	94,802	210,074	63,037	39,233	323,937
17,864	287,345	3,552	40,060	6,145	23,129	69,731	795	2,905	29,899
111,976	515,452	165,956	588,464	289,425	18,992	378,162	146,311	45,419	672,730
633,556	703,634	64,876	468,500	109,094	247,167	660,947	102,293	52,434	618,904
24,691	14,223	884	36,252	13,768	90,291	76,877	10,050	3,670	78,064
32,951	29,622	4,631	39,213	17,492	10,491	26,638	3,160	12,821	34,093
16,050	86,082	13,435	39,223	12,229	7,624	43,454	13,888	12,567	25,618
73,692	129,927	18,950	114,688	43,489	108,406	146,969	27,098	29,058	137,775
$ 967,607	$ 2,220,553	$ 300,707	$ 1,412,729	$ 525,672	$ 492,496	$ 1,465,883	$ 339,534	$ 169,049	$ 1,783,245

Ascension Health Alliance

Details of Consolidated Balance Sheet (continued)

(Dollars in Thousands)

June 30, 2013

	Consolidated Ascension Health Alliance	Consolidated Ascension Health Alliance less Health Ministries Presented	Consolidated Baltimore	Consolidated Birmingham	Consolidated Flint	Consolidated Kalamazoo	Consolidated Lewiston
Liabilities and net assets							
Current liabilities:							
Current portion of long-term debt	$ 90,442	$ 26,796	$ 1,143	$ 1,692	$ 4,248	$ 2,391	$ 386
Long-term debt subject to short-term remarketing arrangements	1,187,125	1,187,125	–	–	–	–	–
Accounts payable and accrued liabilities	2,348,401	1,444,189	40,421	51,261	56,098	45,622	10,632
Estimated third-party payor settlements	456,314	289,834	117	16,006	8,984	13,404	5,652
Due to brokers	493,420	493,420	–	–	–	–	–
Current portion of self-insurance liabilities	210,115	170,711	1,934	1,386	2,553	1,308	782
Other	644,084	434,728	15,904	26,034	62	993	7,120
Total current liabilities	5,429,901	4,046,803	59,519	96,379	71,945	63,718	24,572
Noncurrent liabilities:							
Long-term debt (senior and subordinated)	5,278,866	1,697,249	78,270	115,834	290,872	163,683	26,406
Self-insurance liabilities	553,706	486,547	2,182	3,284	3,311	3,204	157
Pension and other postretirement liabilities	554,368	341,517	–	2,802	9,752	48,437	–
Other	1,099,362	727,708	8,285	66,784	6,319	30,686	1,957
Total noncurrent liabilities	7,486,302	3,253,021	88,737	188,704	310,254	246,010	28,520
Total liabilities	12,916,203	7,299,824	148,256	285,083	382,199	309,728	53,092
Net assets:							
Unrestricted:							
Controlling interest	14,986,302	8,873,840	392,653	393,055	81,365	148,880	112,195
Noncontrolling interests	1,592,356	1,523,448	–	1,128	–	–	–
Unrestricted net assets	16,578,658	10,397,288	392,653	394,183	81,365	148,880	112,195
Temporarily restricted	377,555	237,965	7,930	15,613	4,103	4,674	335
Permanently restricted	174,955	91,802	459	1,433	545	291	–
Total net assets	17,131,168	10,727,055	401,042	411,229	86,013	153,845	112,530
Total liabilities and net assets	$ 30,047,371	$ 18,026,879	$ 549,298	$ 696,312	$ 468,212	$ 463,573	$ 165,622

Consolidated Milwaukee	Consolidated Ministry	Consolidated Mobile	Consolidated Nashville	Consolidated Saginaw & Tawas	Consolidated Tucson	Consolidated Tulsa	Consolidated Waco	Consolidated Washington D.C.	Consolidated Wichita
$ 4,625	$ 16,198	$ 1,041	$ 6,400	$ 2,039	$ 2,534	$ 8,927	$ 757	$ 925	$ 10,340
–	–	–	–	–	–	–	–	–	–
46,909	178,263	16,173	86,651	30,578	62,146	96,244	21,260	33,151	128,803
332	12,276	2,446	16,585	10,225	72,379	2,405	897	4,750	22
–	–	–	–	–	–	–	–	–	–
2,762	–	479	10,023	1,248	1,472	5,500	600	1,028	8,329
13,955	89,771	5,282	27,751	1,578	4,529	10,976	3,452	1,949	–
68,583	296,508	25,421	147,410	45,668	143,060	124,052	26,966	41,803	147,494
316,694	710,719	70,208	407,177	127,466	145,097	514,433	51,835	63,345	499,578
6	–	1,561	3,069	1,713	5,430	12,385	1,950	2,426	26,481
3,232	77,463	53	9,652	–	–	53,595	7,865	–	–
20,337	70,949	9,746	19,611	6,684	39,233	36,559	7,890	6,492	40,122
340,269	859,131	81,568	439,509	135,863	189,760	616,972	69,540	72,263	566,181
408,852	1,155,639	106,989	586,919	181,531	332,820	741,024	96,506	114,066	713,675
540,891	991,800	192,441	792,910	337,660	145,910	703,926	239,989	51,219	987,568
–	1,790	–	2,158	–	–	(89)	–	–	63,921
540,891	993,590	192,441	795,068	337,660	145,910	703,837	239,989	51,219	1,051,489
12,112	20,641	1,277	28,455	5,784	10,226	11,022	2,288	3,764	11,366
5,752	50,683	–	2,287	697	3,540	10,000	751	–	6,715
558,755	1,064,914	193,718	825,810	344,141	159,676	724,859	243,028	54,983	1,069,570
$ 967,607	$ 2,220,553	$ 300,707	$ 1,412,729	$ 525,672	$ 492,496	$ 1,465,883	$ 339,534	$ 169,049	$ 1,783,245

Ascension Health Alliance

Details of Consolidated Balance Sheet
(Dollars in Thousands)

June 30, 2012

	Consolidated Ascension Health Alliance	Consolidated Ascension Health Alliance less Health Ministries Presented	Reclassification	Consolidated Baltimore
Assets				
Current assets:				
Cash and cash equivalents	$ 306,469	$ 227,151	$ –	$ 13,229
Short-term investments	216,914	202,701	–	–
Interest in investments held by Ascension Health Alliance	–	–	(84,930)	1,114
Accounts receivable, less allowances for uncollectible accounts ($1,113,255 in 2012)	1,927,222	1,390,098	–	50,344
Inventories	218,598	154,791	–	5,677
Due from brokers	789,271	789,271	–	–
Estimated third-party payor settlements	159,871	126,544	–	–
Other	752,348	643,257	–	8,737
Total current assets	4,370,693	3,533,813	(84,930)	79,101
Long-term investments	10,468,457	8,907,284	1,449,331	16,889
Interest in investments held by Ascension Health Alliance	–	–	(1,364,401)	180,177
Property and equipment, net	6,473,918	4,225,270	–	216,705
Other assets:				
Investment in unconsolidated entities	943,747	748,948	–	17,409
Capitalized software costs, net	642,596	529,227	–	1,699
Other	876,483	775,215	–	9,011
Total other assets	2,462,826	2,053,390	–	28,119
Total assets	$ 23,775,894	$ 18,719,757	$ –	$ 520,991

Consolidated Birmingham	Consolidated Milwaukee	Consolidated Nashville	Consolidated Saginaw & Tawas	Consolidated Tucson	Consolidated Waco	Consolidated Washington D.C.
$ 13,338	$ 4,663	$ 20,770	$ 6,697	$ 12,362	$ 3,588	$ 4,671
–	–	603	9,094	4,516	–	–
1,536	14,229	30,632	4,629	17,961	10,705	4,124
62,608	87,310	148,817	41,401	69,569	41,201	35,874
9,464	9,631	14,197	6,801	10,984	3,990	3,063
–	–	–	–	–	–	–
5,404	3,696	3,758	9,837	961	8,119	1,552
9,868	32,631	28,166	5,216	17,052	1,696	5,725
102,218	152,160	246,943	83,675	133,405	69,299	55,009
15,394	18,902	30,230	5,753	20,995	303	3,376
156,874	74,110	473,140	287,265	4,636	124,253	63,946
369,969	664,628	484,636	113,007	241,399	107,722	50,582
5,437	21,657	34,862	12,501	90,675	8,678	3,580
1,770	39,124	38,578	7,182	14,572	2,275	8,169
7,939	13,275	35,304	7,736	8,947	12,348	6,708
15,146	74,056	108,744	27,419	114,194	23,301	18,457
$ 659,601	$ 983,856	$ 1,343,693	$ 517,119	$ 514,629	$ 324,878	$ 191,370

Ascension Health Alliance

Details of Consolidated Balance Sheet (continued)
(Dollars in Thousands)

June 30, 2012

	Consolidated Ascension Health Alliance	Consolidated Ascension Health Alliance less Health Ministries Presented	Consolidated Baltimore
Liabilities and net assets			
Current liabilities:			
Current portion of long-term debt	$ 45,363	$ 33,402	$ 626
Long-term debt subject to short-term remarketing arrangements	1,094,425	1,094,425	–
Accounts payable and accrued liabilities	1,979,160	1,567,834	43,391
Estimated third-party payor settlements	457,030	330,867	–
Due to brokers	880,613	880,613	–
Current portion of self-insurance liabilities	206,057	186,014	2,106
Other	435,805	358,459	18,498
Total current liabilities	5,098,453	4,451,614	64,621
Noncurrent liabilities:			
Long-term debt (senior and subordinated)	3,655,406	2,330,137	79,381
Self-insurance liabilities	518,995	499,637	1,913
Pension and other postretirement liabilities	492,366	441,278	3,493
Other	1,087,782	921,680	6,677
Total noncurrent liabilities	5,754,549	4,192,732	91,464
Total liabilities	10,853,002	8,644,346	156,085
Net assets:			
Unrestricted:			
Controlling interest	11,836,414	9,101,543	349,251
Noncontrolling interests	647,236	643,352	–
Unrestricted net assets	12,483,650	9,744,895	349,251
Temporarily restricted	336,027	241,596	15,199
Permanently restricted	103,215	88,920	456
Total net assets	12,922,892	10,075,411	364,906
Total liabilities and net assets	$ 23,775,894	$ 18,719,757	$ 520,991

Consolidated Birmingham	Consolidated Milwaukee	Consolidated Nashville	Consolidated Saginaw & Tawas	Consolidated Tucson	Consolidated Waco	Consolidated Washington D.C.
$ 926	$ 2,532	$ 3,750	$ 1,206	$ 2,001	$ 414	$ 506
–	–	–	–	–	–	–
59,832	62,633	81,337	30,315	78,462	19,969	35,387
19,675	1,738	17,614	7,617	74,337	1,302	3,880
–	–	–	–	–	–	–
1,733	3,008	7,919	1,250	2,307	465	1,255
2,777	5,176	41,048	343	3,286	4,742	1,476
84,943	75,087	151,668	40,731	160,393	26,892	42,504
117,478	321,189	413,371	129,452	147,583	52,571	64,244
3,428	1	2,864	1,627	5,143	1,977	2,405
6,230	17,589	13,531	783	–	9,462	–
66,482	16,565	15,560	5,368	40,796	8,600	6,054
193,618	355,344	445,326	137,230	193,522	72,610	72,703
278,561	430,431	596,994	177,961	353,915	99,502	115,207
365,048	534,523	710,751	332,826	148,264	222,595	71,613
1,302	–	2,582	–	–	–	–
366,350	534,523	713,333	332,826	148,264	222,595	71,613
13,315	13,152	31,229	5,747	9,187	2,052	4,550
1,375	5,750	2,137	585	3,263	729	–
381,040	553,425	746,699	339,158	160,714	225,376	76,163
$ 659,601	$ 983,856	$ 1,343,693	$ 517,119	$ 514,629	$ 324,878	$ 191,370

Ascension Health Alliance

Details of Consolidated Statement of Operations and Changes in Net Assets
(Dollars in Thousands)

Year Ended June 30, 2013

	Consolidated Ascension Health Alliance	Consolidated Ascension Health Alliance less Health Ministries Presented	Consolidated Baltimore	Consolidated Birmingham	Consolidated Flint	Consolidated Kalamazoo	Consolidated Lewiston
Operating revenue:							
Net patient service revenue	$ 16,912,410	$ 10,361,066	$ 419,247	$ 651,936	$ 454,997	$ 541,397	$ 139,838
Less provision for doubtful accounts	1,172,863	797,506	18,230	24,205	16,563	18,544	4,878
Net patient service revenue, less provision for doubtful accounts	15,739,547	9,563,560	401,017	627,731	438,434	522,853	134,960
Other revenue	1,357,663	780,308	12,085	39,997	20,584	35,972	4,375
Total operating revenue	17,097,210	10,343,868	413,102	667,728	459,018	558,825	139,335
Operating expenses:							
Salaries and wages	7,247,681	4,567,793	198,232	219,244	204,060	223,624	52,762
Employee benefits	1,581,587	1,002,854	30,490	46,792	56,617	65,053	11,788
Purchased services	1,030,574	356,892	25,020	84,559	45,083	64,243	13,407
Professional fees	1,128,880	740,103	17,997	15,979	37,184	43,276	8,716
Supplies	2,427,714	1,367,020	59,966	138,758	62,523	74,159	30,127
Insurance	115,521	79,544	886	3,330	1,393	2,680	365
Interest	150,877	67,401	2,737	7,595	10,269	5,694	931
Depreciation and amortization	755,305	455,202	17,661	34,350	11,814	18,126	4,807
Other	2,185,015	1,338,582	32,436	91,757	29,311	56,285	9,162
Total operating expenses before impairment, restructuring, and nonrecurring gains (losses), net	16,623,154	9,975,391	385,425	642,364	458,254	553,140	132,065
Income (loss) from operations before self-insurance trust fund investment return and impairment restructuring and nonrecurring gains (losses), net	474,056	368,477	27,677	25,364	764	5,685	7,270
Self-insurance trust fund investment return	34,985	35,003	–	–	–	–	–
Impairment, restructuring, and nonrecurring gains (losses), net	(111,786)	(147,668)	(1,030)	(4,156)	(2,774)	(1,489)	(500)
Income (loss) from operations	397,255	255,812	26,647	21,208	(2,010)	4,196	6,770
Nonoperating gains (losses):							
Investment return	737,057	604,724	15,619	14,348	12,813	10,657	5,437
Loss on extinguishment of debt	(4,079)	(4,079)	–	–	–	–	–
Gain (loss) on interest rate swaps	61,202	55,298	(17)	5	(63)	(35)	(6)
Income from unconsolidated entities	8,544	4,044	1,308	–	884	–	–
Contributions from business combinations, net	2,021,963	2,021,963	–	–	–	–	–
Other	(77,269)	(73,999)	(1,253)	(416)	(1,110)	(1,286)	(524)
Total nonoperating gains (losses), net	2,747,418	2,607,951	15,657	13,937	12,524	9,336	4,907
Excess (deficit) of revenues and gains over expenses and losses	3,144,673	2,870,033	42,304	35,145	10,514	13,532	11,677
Less noncontrolling interests	131,184	122,083	–	566	–	–	–
Excess (deficit) of revenues and gains over expenses and losses attributable to controlling interest	3,013,489	2,747,950	42,304	34,579	10,514	13,532	11,677

Consolidated Milwaukee	Consolidated Ministry	Consolidated Mobile	Consolidated Nashville	Consolidated Saginaw & Tawas	Consolidated Tucson	Consolidated Tulsa	Consolidated Waco	Consolidated Washington D.C.	Consolidated Wichita
$ 627,323	$ 336,232	$ 267,116	$ 1,233,158	$ 325,126	$ 497,485	$ 265,372	$ 286,577	$ 232,461	$ 273,079
32,113	22,577	19,318	76,041	13,681	45,251	35,334	18,233	14,407	15,982
595,210	313,655	247,798	1,157,117	311,445	452,234	230,038	268,344	218,054	257,097
32,469	214,863	9,682	100,610	8,581	36,926	14,710	13,443	14,162	18,896
627,679	528,518	257,480	1,257,727	320,026	489,160	244,748	281,787	232,216	275,993
249,296	179,165	97,823	418,120	132,001	230,945	113,942	110,711	124,977	124,986
49,138	45,898	15,970	91,851	28,779	42,718	21,140	25,258	18,818	28,423
65,230	43,099	30,145	123,539	44,631	67,213	11,314	17,868	25,476	12,855
48,550	22,608	7,115	67,410	29,607	31,552	8,790	17,635	19,764	12,594
66,824	50,083	53,361	232,769	50,032	81,605	44,606	44,915	27,330	43,636
2,410	1,662	1,644	5,694	1,810	5,822	1,790	1,170	2,595	2,726
11,168	3,226	2,950	14,406	4,595	6,093	5,434	1,829	2,344	4,205
45,622	16,840	10,606	60,228	11,318	22,052	11,760	12,070	7,778	15,071
78,534	164,539	27,434	181,908	26,830	43,252	20,884	33,263	26,481	24,357
616,772	527,120	247,048	1,195,925	329,603	531,252	239,660	264,719	255,563	268,853
10,907	1,398	10,432	61,802	(9,577)	(42,092)	5,088	17,068	(23,347)	7,140
–	–	–	–	–	–	–	(1)	–	(17)
(5,111)	45,607	(351)	177	(1,624)	(7,787)	22,648	(4,101)	(1,161)	(2,466)
5,796	47,005	10,081	61,979	(11,201)	(49,879)	27,736	12,966	(24,508)	4,657
5,462	(12,275)	12,805	41,675	24,614	2,573	(5,451)	10,278	4,641	(10,863)
–	–	–	–	–	–	–	–	–	–
(68)	6,506	(13)	(88)	(56)	(25)	(236)	(10)	14	(4)
–	–	–	–	104	–	–	–	522	1,682
–	–	–	–	–	–	–	–	–	–
(462)	3,931	–	(916)	(292)	(761)	36	(502)	71	214
4,932	(1,838)	12,792	40,671	24,370	1,787	(5,651)	9,766	5,248	(8,971)
10,728	45,167	22,873	102,650	13,169	(48,092)	22,085	22,732	(19,260)	(4,314)
–	(39)	–	7,406	–	–	–	–	–	1,168
10,728	45,206	22,873	95,244	13,169	(48,092)	22,085	22,732	(19,260)	(5,482)

Ascension Health Alliance

Details of Consolidated Statement of Operations and Changes in Net Assets (continued)

(Dollars in Thousands)

Year Ended June 30, 2013

	Consolidated Ascension Health Alliance	Consolidated Ascension Health Alliance less Health Ministries Presented	Consolidated Baltimore	Consolidated Birmingham	Consolidated Flint	Consolidated Kalamazoo	Consolidated Lewiston
Unrestricted net assets, controlling interest:							
Excess (deficit) of revenues and gains over expenses and losses	$ 3,013,489	$ 2,747,950	$ 42,304	$ 34,579	$ 10,514	$ 13,532	$ 11,677
Transfer (to) from sponsors and other affiliates, net	(10,962)	34,395	(7,390)	(8,680)	(4,616)	(5,912)	(2,330)
Contributed net assets	(1,050)	(2,574,751)	–	–	–	–	–
Net assets released from restrictions for property acquisitions	67,418	44,389	8,064	885	390	751	110
Pension and other postretirement liability adjustments	77,011	13,987	424	1,176	(2,219)	5,789	(1,336)
Change in unconsolidated entities' net assets	23,295	17,771	–	–	176	–	–
Other	4,624	2,471	–	47	(1,343)	4	–
Increase in unrestricted net assets, controlling interest, before (loss) gain from discontinued operations	3,173,825	286,212	43,402	28,007	2,902	14,164	8,121
Loss from discontinued operations	(23,937)	(23,937)	–	–	–	–	–
Increase (decrease) in unrestricted net assets, controlling interest	3,149,888	262,275	43,402	28,007	2,902	14,164	8,121
Unrestricted net assets, noncontrolling interest:							
Excess of revenues and gains over expenses and losses	131,184	122,083	–	566	–	–	–
Distributions of capital	(829,989)	(820,355)	–	(731)	–	–	–
Contributions of capital	1,579,187	1,578,269	–	–	–	–	–
Contributions from business combinations	64,738	99	–	(9)	–	–	–
Increase (decrease) in unrestricted net assets, noncontrolling interest	945,120	880,096	–	(174)	–	–	–
Temporarily restricted net assets, controlling interest:							
Contributions and grants	89,220	61,215	2,632	5,016	753	1,532	173
Investment return	17,232	13,390	186	309	152	286	1
Net assets released from restrictions	(110,213)	(70,917)	(10,087)	(2,983)	(798)	(2,047)	(167)
Contributions from business combinations	44,201	–	–	–	–	–	–
Other	1,088	3,251	–	(44)	–	57	–
Increase (decrease) in temporarily restricted net assets, controlling interest	41,528	6,939	(7,269)	2,298	107	(172)	7
Permanently restricted net assets, controlling interest:							
Contributions	2,664	2,326	–	19	11	5	–
Investment return	1,598	1,622	3	39	1	–	–
Contributions from business combinations	67,846	2	–	–	–	–	–
Other	(368)	(249)	–	–	–	–	–
Increase in permanently restricted net assets, controlling interest	71,740	3,701	3	58	12	5	–
Increase in net assets	4,208,276	1,153,011	36,136	30,189	3,021	13,997	8,128
Net assets, beginning of year	12,922,892	9,574,044	364,906	381,040	82,992	139,848	104,402
Net assets, end of year	$ 17,131,168	$ 10,727,055	$ 401,042	$ 411,229	$ 86,013	$ 153,845	$ 112,530

Consolidated Milwaukee	Consolidated Ministry	Consolidated Mobile	Consolidated Nashville	Consolidated Saginaw & Tawas	Consolidated Tucson	Consolidated Tulsa	Consolidated Waco	Consolidated Washington D.C.	Consolidated Wichita
$ 10,728	$ 38,700	$ 22,873	$ 95,244	$ 13,169	$ (48,092)	$ 22,321	$ 22,732	$ (19,260)	$ (5,482)
(12,041)	–	(4,513)	(21,085)	(8,968)	38,608	–	(5,330)	(3,100)	–
–	920,665	(250)	–	–	–	664,297	–	–	988,989
2,208	–	171	6,816	1,118	1,687	–	96	409	324
5,473	30,566	675	1,184	(487)	–	16,903	142	1,101	3,633
–	–	–	–	–	5,348	–	–	–	–
–	1,869	760	–	2	95	405	(246)	456	104
6,368	991,800	19,716	82,159	4,834	(2,354)	703,926	17,394	(20,394)	987,568
–	–	–	–	–	–	–	–	–	–
6,368	991,800	19,716	82,159	4,834	(2,354)	703,926	17,394	(20,394)	987,568
–	(39)	–	7,406	–	–	–	–	–	1,168
–	(57)	–	(7,830)	–	–	–	–	–	(1,016)
–	817	–	–	–	–	–	–	–	101
–	1,069	–	–	–	–	(89)	–	–	63,668
–	1,790	–	(424)	–	–	(89)	–	–	63,921
63	1,612	837	3,109	1,145	3,649	2,301	540	3,424	1,219
–	(113)	23	2,358	248	606	(179)	62	–	(97)
(2,208)	–	(980)	(7,200)	(1,356)	(2,896)	(2,203)	(536)	(4,210)	(1,625)
–	21,229	–	–	–	–	11,103	–	–	11,869
1,105	(2,087)	(3)	(1,041)	–	(320)	–	170	–	–
(1,040)	20,641	(123)	(2,774)	37	1,039	11,022	236	(786)	11,366
–	90	–	150	33	–	–	30	–	–
–	(146)	–	–	79	–	–	–	–	–
–	51,129	–	–	–	–	10,000	–	–	6,715
2	(390)	–	–	–	277	–	(8)	–	–
2	50,683	–	150	112	277	10,000	22	–	6,715
5,330	1,064,914	19,593	79,111	4,983	(1,038)	724,859	17,652	(21,180)	1,069,570
553,425	–	174,125	746,699	339,158	160,714	–	225,376	76,163	–
$ 558,755	$ 1,064,914	$ 193,718	$ 825,810	$ 344,141	$ 159,676	$ 724,859	$ 243,028	$ 54,983	$ 1,069,570

Ascension Health Alliance

Details of Consolidated Statement of Operations and Changes in Net Assets

(Dollars in Thousands)

Year Ended June 30, 2012

	Consolidated Ascension Health Alliance	Consolidated Ascension Health Alliance less Health Ministries Presented	Consolidated Baltimore
Operating revenue:			
Net patient service revenue	$ 15,297,559	$ 10,990,636	$ 413,223
Less provision for doubtful accounts	972,171	760,350	13,612
Net patient service revenue, less provision for doubtful accounts	14,325,388	10,230,286	399,611
Other revenue	967,252	717,557	9,909
Total operating revenue	15,292,640	10,947,843	409,520
Operating expenses:			
Salaries and wages	6,544,753	4,821,591	200,322
Employee benefits	1,426,722	1,090,379	32,560
Purchased services	734,396	309,807	20,812
Professional fees	1,021,582	752,589	18,033
Supplies	2,260,901	1,536,041	64,639
Insurance	100,834	74,724	962
Interest	131,310	77,876	2,966
Depreciation and amortization	662,362	451,080	17,996
Other	1,782,172	1,270,545	29,346
Total operating expenses before impairment, restructuring, and nonrecurring gains (losses), net	14,665,032	10,384,632	387,636
Income (loss) from operations before self-insurance trust fund investment investment return and impairment restructuring and nonrecurring gains (losses), net	627,608	563,211	21,884
Self-insurance trust fund investment return	17,197	17,197	–
Impairment, restructuring, and nonrecurring gains (losses), net	286,046	166,713	21,547
Income (loss) from operations	930,851	747,121	43,431
Nonoperating gains (losses):			
Investment return	(135,605)	(110,356)	(3,289)
Loss on extinguishment of debt	(2,813)	(2,727)	–
Gain (loss) on interest rate swaps	(74,846)	(75,687)	56
Income from unconsolidated entities	8,802	3,785	4,889
Contributions from business combinations, net	326,333	326,333	–
Other	(69,221)	(63,858)	(1,176)
Total nonoperating gains (losses), net	52,650	77,490	480
Excess (deficit) of revenues and gains over expenses and losses	983,501	824,611	43,911
Less noncontrolling interests	13,154	3,802	–
Excess (deficit) of revenues and gains over expenses and losses attributable to controlling interest	970,347	820,809	43,911

Consolidated Birmingham	Consolidated Milwaukee	Consolidated Nashville	Consolidated Saginaw & Tawas	Consolidated Tucson	Consolidated Waco	Consolidated Washington D.C.
$ 653,472	$ 658,781	$ 1,213,068	$ 341,003	$ 476,761	$ 305,501	$ 245,114
49,146	30,293	48,866	8,541	34,951	25,909	503
604,326	628,488	1,164,202	332,462	441,810	279,592	244,611
30,667	43,747	101,037	6,978	31,212	11,610	14,535
634,993	672,235	1,265,239	339,440	473,022	291,202	259,146
209,474	267,331	424,213	134,261	244,570	114,672	128,319
41,773	55,922	93,645	23,467	43,711	24,633	20,632
77,901	57,116	125,016	38,604	74,182	12,579	18,379
11,150	68,831	65,537	27,205	45,481	14,089	18,667
129,966	69,448	231,069	56,600	93,039	49,962	30,137
4,717	2,723	4,975	1,695	6,452	732	3,854
7,808	11,785	15,562	4,978	5,973	1,972	2,390
33,620	47,469	56,945	12,125	24,023	12,113	6,991
87,659	78,781	182,142	25,527	41,659	41,550	24,963
604,068	659,406	1,199,104	324,462	579,090	272,302	254,332
30,925	12,829	66,135	14,978	(106,068)	18,900	4,814
–	–	–	–	–	–	–
10,819	21,381	41,199	21,410	(21,887)	6,171	18,693
41,744	34,210	107,334	36,388	(127,955)	25,071	23,507
(1,456)	(1,077)	(9,495)	(6,369)	(352)	(2,021)	(1,190)
(12)	–	(2)	(72)	–	–	–
82	225	289	87	110	37	(45)
–	–	–	47	–	–	81
–	–	–	–	–	–	–
(364)	(575)	(784)	(287)	(1,776)	(487)	86
(1,750)	(1,427)	(9,992)	(6,594)	(2,018)	(2,471)	(1,068)
39,994	32,783	97,342	29,794	(129,973)	22,600	22,439
462	–	8,890	–	–	–	–
39,532	32,783	88,452	29,794	(129,973)	22,600	22,439

Ascension Health Alliance

Details of Consolidated Statement of Operations and Changes in Net Assets (continued)

(Dollars in Thousands)

Year Ended June 30, 2012

	Consolidated Ascension Health Alliance	Consolidated Ascension Health Alliance less Health Ministries Presented	Consolidated Baltimore
Unrestricted net assets, controlling interest:			
Excess (deficit) of revenues and gains over expenses and losses	$ 970,347	$ 820,809	$ 43,911
Transfer (to) from sponsors and other affiliates, net	(15,189)	38,694	(5,111)
Contributed net assets	(400)	(400)	–
Net assets released from restrictions for property acquisitions	68,892	49,189	1,824
Pension and other postretirement liability adjustments	(439,662)	(301,442)	(27,779)
Change in unconsolidated entities' net assets	(15,890)	(11,623)	–
Other	9,206	9,890	–
Increase in unrestricted net assets, controlling interest, before (loss) gain from discontinued operations	577,304	605,117	12,845
Loss from discontinued operations	(73,521)	(73,521)	–
Increase (decrease) in unrestricted net assets, controlling interest	503,783	531,596	12,845
Unrestricted net assets, noncontrolling interest:			
Excess of revenues and gains over expenses and losses	13,154	3,802	–
Distributions of capital	(575,618)	(566,546)	–
Contributions of capital	1,166,961	1,167,028	–
Increase in unrestricted net assets, noncontrolling interest	604,497	604,284	–
Temporarily restricted net assets, controlling interest:			
Contributions and grants	100,880	74,330	4,313
Investment return	(638)	92	50
Net assets released from restrictions	(104,028)	(74,184)	(3,332)
Contributions from business combinations	14,764	14,764	–
Other	(6,514)	(7,242)	–
Increase (decrease) in temporarily restricted net assets, controlling interest	4,464	7,760	1,031
Permanently restricted net assets, controlling interest:			
Contributions	5,082	4,687	33
Investment return	(242)	(252)	(6)
Contributions from business combinations	1,573	1,573	–
Other	(2,642)	(1,938)	–
Increase in permanently restricted net assets, controlling interest	3,771	4,070	27
Increase in net assets	1,116,515	1,147,710	13,903
Net assets, beginning of year	11,806,377	8,927,701	351,003
Net assets, end of year	$ 12,922,892	$ 10,075,411	$ 364,906

Consolidated Birmingham	Consolidated Milwaukee	Consolidated Nashville	Consolidated Saginaw & Tawas	Consolidated Tucson	Consolidated Waco	Consolidated Washington D.C.
$ 39,532	$ 32,783	$ 88,452	$ 29,794	$ (129,973)	$ 22,600	$ 22,439
(7,371)	(8,856)	(15,145)	(6,046)	(5,430)	(3,798)	(2,126)
–	–	–	–	–	–	–
6,801	3,592	3,729	1,505	2,016	209	27
(12,027)	(19,512)	(28,378)	(22,236)	–	(7,133)	(21,155)
–	–	–	–	(4,267)	–	–
11	–	–	(5)	(55)	(91)	(544)
26,946	8,007	48,658	3,012	(137,709)	11,787	(1,359)
–	–	–	–	–	–	–
26,946	8,007	48,658	3,012	(137,709)	11,787	(1,359)
462	–	8,890	–	–	–	–
(358)	–	(8,714)	–	–	–	–
(21)	–	(46)	–	–	–	–
83	–	130	–	–	–	–
3,536	187	6,541	1,705	3,964	975	5,329
49	–	(652)	(70)	(92)	(15)	–
(8,026)	(3,592)	(4,926)	(1,825)	(3,821)	(472)	(3,850)
–	–	–	–	–	–	–
(44)	903	(523)	(16)	61	90	257
(4,485)	(2,502)	440	(206)	112	578	1,736
8	–	–	316	–	38	–
–	–	–	16	–	–	–
–	–	–	–	–	–	–
–	(674)	–	23	(50)	(3)	–
8	(674)	–	355	(50)	35	–
22,552	4,831	49,228	3,161	(137,647)	12,400	377
358,488	548,594	697,471	335,997	298,361	212,976	75,786
$ 381,040	$ 553,425	$ 746,699	$ 339,158	$ 160,714	$ 225,376	$ 76,163

Tab 16

Attachment C
Contribution to the Orderly Development of Health Care – 2

Letters of Support

Letters to be submitted separately

Tab 17

Attachment C
Contribution to the Orderly Development of Health Care – 5

Performance Improvement Plan

Saint Thomas Health
Quality and Patient Safety Improvement Plan
Fiscal Year 2014
(July 1, 2013 – June 30, 2014)

I. Introduction

The hospitals of Saint Thomas Health (STHe) are committed to the continuous improvement of the quality, reliability and safety of the care they provide. This plan serves as the supporting document for the organizational structures and functions that are the vehicles of safe, reliable, high-quality patient care.

The STHe governing board has the ultimate responsibility for the quality and safety of care provided throughout the system. Any changes or revisions to this plan are presented for approval to the STHe Clinical Quality Committee of the Board of Trustees annually and on an as-needed basis. Additional approval of this plan is required annually by the STHe Board of Directors.

All data used within the STHe quality and patient safety program is legally protected from discovery by TCA 63-6-219 and the Ascension Health Patient Safety Organization (PSO) as Patient Safety Work Product (PSWP).

II. About the Plan

This plan is based on the concepts of continuous improvement, collaboration and a cultural approach to patient safety and quality that strives to achieve the following:

- Creation of a just culture that is safe for patients, associates, physicians, volunteers and visitors and minimizes risk to system assets.
- Promotion of respect, sensitivity and caring in regard to our patients' individual needs and expectations.
- Efficient, effective, timely and safe use of available resources and ongoing process improvements.
- Responsible decision-making and priority-setting through interdisciplinary collaboration and by utilization of available data.
- Process and outcome monitoring that reliably measures the quality and safety of patient care.
- Comparative evaluation of organizational and system measurements against established benchmarks and industry norms.
- Ongoing integration of established best practices into our delivery of patient care.
- Internal and external recognition of our commitment to safe, reliable, high quality care.
- Utilization of common methodologies in the design, testing, implementation and evaluation of improvements.

- The goals set forth by Ascension Health's High Reliability Organization – Healing without Harm by 2014.
- The goals set forth by Ascension Health's participation in CMS's Healthcare Engagement Network (Partnership for Patients) grant.

For the purposes of prioritization of needs and evaluation of effectiveness in FY 14, the following factors have been identified in consideration of the quality and patient safety program:

Key Innovations

- *Successful* early-adoption of Ascension Health's High Reliability Organization for Healing without Harm by 2014 with observed 50% reduction in serious safety events across the STHe since 2008
- Addition of a STHe Process Improvement/LEAN effort with dedicated leadership and system-wide scope
- Deployment of CPOE at ST Rutherford Hospital and achievement of Stage 1 Meaningful Use
- Revision and expansion of STHe system-wide quality reporting and scorecards
- Establishment of the Ministry Collaborative Council (MCC) to effect system-wide clinically focused performance improvement initiatives to improve quality of care and patient safety as well as to meet AH HEN goals
- Reorganization of the facility-centric quality, safety and risk model into a consolidated system-level STHe Quality Department
- Establishment of a STHe Readmissions Avoidance Program (RAP) in partnership with Mission Point
- Inclusion of Infection Prevention into the STHe Quality Department in facilitate prevention of Healthcare Associated Infections (HACs)
- Deployment of a concurrent abstraction model for the abstraction of Core Measures is designed to improve clinical outcomes and compliance with CMS standards of care
- Unification of existing facility-centric HEN teams into STHe system teams.

Strengths and Accomplishments

- Senior leadership engagement in quality and safety, most notably the *HRH program and CMS HEN program*
- Medical staff championship of quality initiatives and the Healing Without Harm (HWH) program
- Associate-level engagement with the HWH program and the safety event reporting structure
- Strong quality and safety departmental leadership at each facility
- "Priority for Action" success within the Ascension Health System

- Proactive facility and medical staff leadership throughout the quality and patient safety committee structures
- Continued CMS Disease Specific Certification recognition for multiple clinical programs within STHe.
- Participation in the National Surgical Quality Improvement Program (NSQIP) at both ST West and Midtown Hospitals.
- Unification of the existing facility PSOs into a STHe system level PSO thus facilitating the sharing of vital patient safety information across STHe
- Implementation of a successful Safe Patient Handling initiative at Saint Thomas West Hospital (STWH) with reduction in employee injuries related to patient handling.
- Successful Process Improvement (PI) activities as each hospital; typically using LEAN methodologies.
- Participation in the Tennessee Initiative for Perinatal Quality (TIPQC) by Saint Thomas Midtown Hospital and Saint Thomas Rutherford Hospital.

Weaknesses

- Integration of process improvement and leadership expectations into daily work functions at the associate level
- Engagement of mid-level leadership and front-line staff in performance improvement due to real or perceived resource limitations and competing priorities
- Inadequate unit level managerial accountability for safe patient and associate practices
- Incomplete and unreliable sharing of patient safety and risk information between facilities
- Uncoordinated patient transitions between the inpatient and outpatient environments with resultant unacceptably high readmissions for our patients
- Inadequate education of front line staff in quality and safety standards effecting patient care
- Inconsistency in physician peer review processes and incorporation of quality and safety metrics performance data in credentialing and OPPE and FPPE efforts
- Incomplete documentation of processes and reporting of performance metrics for the Quality information Center internally
- Continued financial losses due to CMS mandated readmission penalties
- Fragmentation and incoordination in clinical data analytic processes and reporting
- Active cross-functional performance improvement teams driving PI and best practices across the system using LEAN methodologies
- Orientation to performance improvement for new leaders and associates
- Consistency in core measures performance
-

- Efficient and effective communication methods to provide timely feedback to front-line staff and physicians relating to quality and safety performance
- Integration of electronic and manual data management processes
- Failure to leverage our Cerner investment in order to drive clinical quality interventions via the EHR
- Lack of a quality reporting standard for all the hospitals in the system
- Lack of physician oversight and participation in collection and use of clinical quality data
- Lack of physician support for meeting national quality metrics unless there is compelling evidence of improved quality outcomes in association with interventions mandated by those metrics.

Opportunities

- Utilization of LEAN improvement methods to eliminate waste and add value to processes
- Leveraging of the relationship between quality and information technology to advance our ability to interface with clinical databases, maximize electronic resources and develop strategies for real-time abstraction of concurrent data
- Identification of common data sets and coalescence of data definitions with clinical workflow and extraction methods
- Further integration with the Human Resources Department in order to advance nursing and associate education to improve quality and safety performance
- Inadequate or non-existent patient and family representation on system quality and safety committees
- Inadequate external community reporting of STH quality and safety metrics for all facilities within STH
- Improvement in care coordination across STH in order to decrease readmissions
- Extension of Safe Patient Handling initiatives across STH
- Increased use of Cerner and our EHR platforms to prompt and drive clinical quality initiatives and interventions.
- Further reduction in patient harm by participation in Ascension Health's Healthcare Engagement Network
- Further partnership with the Tennessee Hospital Association's Center for Patient Safety to drive quality and patient safety behavior and programs

Threats

- Unfunded mandates and multiple external reporting priorities that require utilization of existing resources and the limitations those mandates create in our ability to focus on internal quality needs and opportunities
- Private Insurer Pay for Performance Plans
- Uncertainty regarding CMS and AHRQ public reporting of quality and safety indicators.

- Recovery audit contractors as related to quality outcomes and physician performance
- Reductions in revenue and patient service volumes
- Lack of alignment with independent physician practices
- Anticipated pay for performance initiatives from private insurers
- Capital budget restraints from Ascension Health
- CMS Value Base Purchasing which represents ongoing significant potential for loss of reimbursement if Core measure or HCAHPS performance does not improve.
- Significant financial penalties for failure to meet CMS readmission standards.

III. Approach to Performance Improvement

Principles and Key Terms

- Patient Focus – High reliability organizations and those with established quality reputations focus on exceeding patient expectations.
- Recovery-oriented – Services are characterized by a commitment to holistic, reverent care that promotes flexibility, choice and patient-defined treatment goals.
- Employee empowerment – Effective programs involve associates at all levels of the organization for the purpose of improving quality and increasing subsidiarity.
- Leadership commitment – Strong and proactive leadership throughout the organization maintains focus on quality and safety goals that are consistent with the organization's mission and strategic plan.
- Chartering – To achieve effective outcomes in an efficient and timely manner, performance improvement initiatives are chartered. Chartering encourages and sustains:
    - Setting of priorities
    - Strategic alignment of initiatives with the Mission, Vision and Values
    - Focus on scope, timeline and organizational relevance
    - Collaboration with and coordination of improvement efforts across the system
- Affiliate Physician Engagement – Physician involvement throughout quality and patient safety improvement processes greatly increases the potential success of those efforts.
- LEAN Process Improvement Methodology applied to the healthcare environment using the principles of the Toyota Production System.

IV. Strategic Goals Healing Without Harm and Patient Experience

Strategic Goal #1 – High Reliability Organization and Healing without Harm by 2014

STHe is pursuing four initiatives to build a high-reliability, safety-focused culture as follows:

1. Recognition of safety as an organizational imperative
2. Integration of error-prevention behaviors into all daily work processes
3. Focused efforts to simplify work processes
4. Event analysis which involves key stakeholders and focuses on communication of lessons-learned and proactive safety precepts
5. Integration of HRH and HWH data into physician credentialing (OPPE and FPPE)

The HWH program is the primary strategic quality initiative throughout STHe facilities and remains a top priority throughout STHe for FY 14. Metrics related to the HWH program that will be reported at both the facility and system board levels include:

- Serious Safety Event Rate per 10,000 Adjusted Patient Days
- Number of Serious Safety Events, Precursor Safety Events and Near-Miss Events
- Hospital-Acquired Conditions

In addition, metrics related to the HWH program that will be reported at the facility leadership level include:

- Number of "Red Rule" Violations
- Number of "Déjà vu" Events Resulting in Serious Safety Events

Strategic Goal #2 – Priorities for Action

Priorities for Action (PFA) are specific measures, defined by Ascension Health and reported at the facility, Saint Thomas Health and Ascension Health corporate levels. Priorities for Action for FY 14 include:

- Ventilator Associated Pneumonia in the ICU
- Rate of Central Line Sepsis in the ICU
- Facility-Acquired Pressure Ulcer Rate
- Rate of Falls with Serious Injury
- Rate of Birth Trauma
- Neonatal Mortality Resulting from a Serious Safety Event
- Overall Neonatal Mortality

- Risk-Adjusted Mortality
- Clean Surgical Site Infection Rate
- FY 14Obstetrical and Perinatal Care Measures

Strategic Goal #3 – Core Measures

All STHe facilities collect and report Core Measures for both internal and external (public-reporting) purposes as follows:

- Pneumonia
- Heart Failure
- Acute Myocardial Infarction
- Surgical Care Improvement Project
- IMM/IED
- Surgical HOP
- Medical HOP
- Early Elective Delivery
- VTE
- ED Throughput
- Stroke
- Hospital Acquired Conditions
- Hospital acquired Infections

Core measure compliance remains a top priority for FY 14 and into the foreseeable future in part due to the financial penalties tied to Value Based Purchasing (VBP) initiatives of CMS. At the facility level, core measures are reported at the leadership, Medical Executive Committee and board levels. Composite facility performance is also reported to the STHe Board of Trustees. (Attachment 2)Incidences of non-compliance are identified at the patient level for investigation and follow-up and unit-level performance data is analyzed for patterns, trends and process improvement opportunities. Every six months, physicians across STHe are evaluated to include their core measures results in addition to other key quality metrics as part of the FPPE/OPPE process.

Strategic Goal #4 – Exceptional Patient Experience

With direction from the Ascension Health Experience Team, the facilities of STHe strive to achieve the highest possible level of satisfaction as experienced by our patients, associates and physicians.

Patient satisfaction/experience and HCAHPS measurements are conducted regularly by Professional Research Consultants, Inc. to include a patient sampling of both inpatient and outpatient units with unit-level results available to hospital and medical staff leadership on a monthly basis.

As part of our commitment to the patient's experience of care within STHe facilities, the following strategies have been employed:

- Closed-loop feedback
- Patient rounding
- Support of associate engagement, empowerment and alignment
- Development of emotional and spiritual care
- Expectation of efficient workflow as evidenced by perceptions of improved coordination, communication and cooperation among all those involved in the patient's experience of care

Key metrics reported to the STHe Board of Trustees, System and Facility Leadership and Medical Staff include but not limited to the following:

- INPT NPS
- ED NPS
- OP NPS
- HCAHPS Overall

For FY 14, the Patient Experience goals for each facility are as follows:

Facility	IPNPS	EDNPS	OPNPS	HCAHPS (Overall)
Saint Thomas West Hospital	85	78.7	88	79.0
Saint Thomas Midtown Hospital	78	64.6	77	78.6
Saint Thomas Rutherford Hospital	68	51.6	74	79.3

Strategic Goal #5: Associate Safety:

STHe Senior Leaders support the Integration of Associate Safety into the Overall High Reliability Organization Initiative.

STHe continues to pursue four initiatives to build a high-reliability, safety-focused culture as follows:

1. Recognition of safety (both patient and associate) as an organizational imperative.
2. Integration of error-prevention behaviors into all daily work processes.
3. Focused efforts to simplify work processes.

4. Associate injury event apparent cause analysis (ACA) which involves key stakeholders and focuses on communication of lessons-learned and proactive safety precepts.

The HWW program is the primary strategic quality initiative throughout STHe facilities. Associate Safety will be incorporated into the HWH program in FY14 for all STHe facilities. Associate Safety specific metrics will be presented monthly to the Safety Coaches and in FY14 will be reported at the various STHe Management/leadership meetings (Organizational Update, Management Council, etc.).

Metrics related to the Associate Safety program that will be reported at the facility leadership meeting include:

- Overall Facility Injury Rate
- Overall Facility DART rate
- "Top 3" Injury/Event types
- # of Hazard Concern Reports for the month and presentation of the associate safety "Hazard Concern" reporting award

- Ensure all STHe facilities are below the National Average for Overall Associate Injury Rate

  All of the STHe hospital facilities are required by law to have and maintain an OSHA injury log. Any associate injury event requiring more than first aid is considered to be OSHA Recordable and is added to the OSHA log for that facility.

- Ensure all STHe facilities are below the National Average for Associate Injury DART Rate

  Any injury event that results in the associate incurring days away, restricted time or transfers (DART) from their normal working environment is counted towards that facilities DART rate.

- Spread OSHA VPP (Voluntary Protection Program)

  Saint Thomas Midtown Hospital was the first and is still the only hospital in the State of Tennessee to receive VPP certification. VPP certification recognizes excellence in Health and Safety programs. In FY14, we will continue the "spread" of the lessons-learned and best health and safety practices across STHe.

- Support the various Hospital Engagement Networks (HEN) and teams

Associate safety plays a vital role in ensuring that the hospital environment is safe for patients to receive the highest quality care. Proper hand-washing and PPE usage plays a huge role in reducing central-line associated blood stream infections. Associates who follow the established patient handling and mobilization techniques reduce the skin "shearing" which can lead to pressure ulcers.

Strategic Goal #6: One Patient One Chart

The accelerated evolution of STHe into an integrated digital healthcare environment is paramount if STHe is to meet the challenges of the new health care landscape - delivery high quality and cost effective care, satisfaction of regulatory and payer mandates, and effectively delivery of population health management. This evolution will require:

- Clinical process re-engineering towards standardized digital workflows supported by modernized IT infrastructure
- Architecture and technologies that drive multidisciplinary care collaboration across care venues and provide a continuum, patient centric view of clinical data
- Technologies that seamlessly engage the consumer/patient across the spectrum of their interaction with STHe

Enterprise analytics platforms that facilitate not only insight into near real-time retrospective outcomes performance, but support the necessary migration to prescriptive, evidence based care delivery buttressed by predictive outcomes modeling.

STHe has codified the integrated, system-wide approach to address the requirements outlined above, in the single over-arching strategy - ***One Patient, One Chart (OPOC)***. The FY15 OPOC initiatives, that in aggregate comprise the FY14 Quality Goal #5, are outlined below.

Clinical process re-engineering

High reliability health care delivery is dependent upon reducing the complexity of the systems that deliver that care. The systematic replacement of clinical process variation with system-wide process standards based on clinical evidence and lean engineering methodology is the *sine qua non* for that reduction in complexity. A central consideration this approach is the ability of new processes to account for regulatory, payer and business mandates. Organizational structures that will

systematically delivery this transformation is requisite.

- *OPOC Initiative 1: Creation of a clinical process re-engineering group within the Quality Department with clearinghouse and prioritization authority relative to all clinical process re-engineering across STHe by 10/1/2013*
- *OPOC Initiative 2: Achievement of Meaningful Use Stage I (YR2) and Meaningful Use Stage II (YR1). ST-Midtown, ST-Rutherford, and ST-West have achieved Meaningful Use Stage 1 (YR1). These 3 campuses will achieve Meaningful Use Stage 1 (YR2) by 10/1/2013. In addition these 3 campuses will achieve the increased EHR adoption targets of Meaningful Use Stage II (YR1) by 7/1/2013.*

Re-engineering of clinical process to standard workflows that effectively use digital technology is absolutely dependent upon a robust underlying infrastructure that ultimately delivers "technology as a utility" - reliability, access and performance levels that strive to make the technology transparent to end-users. In FY13 major upgrades to the core infrastructure (switches, edge routers, fiber to clinical device) were completed, and the Managed Virtual Desktop (MVD) initiative was started. MVD is the migration from standalone clinical PCs to a centralized, server-based architecture that provides greater system performance management and allows for enhanced system access and reliability for end-users. MVD completion across the system is foundational to our migration to "technology as a utility".

- *OPOC Initiative 3: Completion of the Managed Virtual Desktop (MVD) clinical computing environment across STHe by 9/1/1013*

Architecture / technologies supporting collaborative patient-centric care

Population health management is the statistical result of the aggregated effects of a multitude of individual interactions between patients, providers, and healthcare systems. Patient specific, coordinated and collaborative health care delivered by a multidisciplinary team across the continuum of care is a hallmark of systems that successfully manage population health. The core technical requirement for this is the ability to deliver the right clinical dataset, at the right time, to the appropriate provider at the point of care, in a manner that integrates into the venue specific workflow. Attributes of systems that are successful in this regard include:

1) Consolidation of enterprise ambulatory EHRs to single integrated platforms,

2) Cross venue Health Information Exchange (HIE) between acute care EHRs, ambulatory EHRs and other clinical data sources, and

3) Effective communication tools between the disparate providers and venues of care that are collectively accountable for the health and wellbeing of an individual patient.

STHe will address each of these attributes under a specific OPOC FY14 initiative.

- *OPOC Initiative 4: STPS Ambulatory EHR Consolidation from 6 unique EHR domains to a single enterprise EHR domain by 7/1/2014*
- *OPOC Initiative 5: Expansion of OneChart, the proprietary STHe HIE. OneChart aggregates clinical data from the acute care Cerner EHR and the ambulatory NextGen EHRs to give providers a patient centric cross continuum view to clinical data. This initiative will aim to expand the number of end-users with access to OneChart from the current 15 pilot providers to a minimum of 100 providers 1/1/2014, and 250 providers by 7/1/2014.*
  OPOC Initiative 6: Implementation of Direct-Protocol secure provider-to-provider communication platform. This platform, deployed in coordination with MissionPoint Health Partners will enroll 500 providers by 7/1/2014.

Patient Engagement

Increasingly integrated health care delivery systems will distinguish themselves on the basis of the seamlessness with which they interact with patients, and their ability to engage with customers (both current and prospective) in a pro-active and contextually aware fashion. STHe has made significant investments in these capabilities through the implementation of the STHe Patient Portal, the STHe Consumer Portal and a sophisticated Customer Relationship Management (CRM) solution. However, at present these platforms are not integrated, and thus cannot realize their full potential as quality of care and business drivers. In addition the STPS ambulatory environment is not a component of the portal architecture. These needs will be addressed in

FY 14.

- *OPOC Initiative 7: Delivery of a seamless platform for patient interaction (viewing of clinical records, scheduling of appointments, communication to providers/practices, and participation in STHe condition specific or population wellness initiatives). This will be achieved by the integration of STHe patient portal, consumer portal and CRM platforms by 7/1/2014.*

- *OPOC Initiative 8: Expansion of STHe patient portal architecture to encompass STPS ambulatory practices/providers by 7/1/2014.*

Enterprise Analytics Platform

The currency of the new healthcare landscape is data. The ability to aggregate data from disparate sources (clinical and claims), semantically normalize that data, provide both retrospective and predictive analytics on a time scale that matches external demands, and present those analytics in a format that can be quickly understood by providers, will distinguish those healthcare systems that survive the turbulence of health care reform. Ascension Health has committed to the implementation of the Humedica Business Intelligence (BI) platform as the corporate standard; the AH pilot implementation of that platform at STHe was completed in Q3 FY13. The Humedica platform aggregates clinical data from the acute care Cerner EHR and the ambulatory NextGen EHRs, as well as payer claims data, and allows for both retrospective and predictive analytics for various population cohorts. STHe will expand the incorporation of Humedica derived retrospective and prospective analytics into clinical and business processes in FY14.

- *OPOC Initiative 9: As appropriate, based on timeliness requirements, the Humedica platform will be used for retrospective performance analytics for both the inpatient and ambulatory venues (NextGen practice subset of STPS). This incorporation will be ongoing throughout FY14.*
- *OPOC Initiative 10: The Ascension Heath Clinical Integration Council ambulatory provider metrics will be produced for STPS providers (NextGen practice subset) from Humedica on a retrospective quarterly basis beginning 10/1/2013.*
- *OPOC Initiative 11: STHe will begin the evaluation of Humedica based population specific predictive modeling as applied to the Congestive Heart Failure and Chronic Obstructive Disease cohorts. This will begin*

in Q1 FY14 and, if validated for the STHe population, will be utilized in prospective population management during Q3/Q4 of FY14.

V. Performance Improvement Structures

System Structure

The Ministry Collaborative Council (MCC) operates as a decision making body for STHe addressing performance improvement opportunities that impact clinical quality, patient and associate safety, regulatory compliance, and operational efficiency.
The goals and functions of the group include:

- Responsible for developing and approving performance improvement initiatives to impact clinical care in the following areas:
  - Patient care delivery
  - Patient Safety
  - Regulatory Compliance
  - Standardizing clinical processes across STHe venues of care by the elimination of care variation with introduction of standard processes and protocols.
- Assuring highly reliable clinical care within STHe
- Optimizing clinical use of the EHR to improve care and outcomes

The Medication Management Oversight Committee (MMOC) operates as a subcommittee of the MCC to analyze and address medication-process specific challenges as related to medication safety, medication ordering and administration and formulary development.

The goals and functions of this group include:

- Awareness and analysis of safety issues impacting bedside medication administration such as bar code technology, patient identification, smart pump integration, nursing-pharmacy communications, etc.
- Recommendations for capital planning related to medication delivery systems and IT integration
- Work toward building a common STHe medication formulary to facilitate cost containment and efficiency
- Oversight of the Ascension Health medication safety Priority for Action efforts.

The Saint Thomas Health (STHe) Clinical Foundation Suite (CFS) Governance Council (GC) is the primary group charged with setting the strategic goals, priorities and timelines for the implementation of the electronic health record. This multi-disciplinary group includes the CEO, CMO, CNO, IT Director as well as 5 physicians (including MEC members) from each campus.

This group is supported by the CIO, CMIO, Director of Pharmacy Informatics, Director of Nursing Informatics, Physician Network Executive and Corporate Compliance Officer. The STHe CFS GC meets every 6 weeks and provides multi-disciplinary input on HIT/EMR strategic direction, prioritization and budgeting recommendations relative to HIT initiatives, evaluation of HIT/EMR implementation progress, and oversight relative to HIT/EMR impact on clinical outcomes, quality and provider workflow. The STHe CFS GC interacts communicates with the STHe IT Shared Governance Council, the Quality / Patient Experience Council and the campus-specific MECs. It directs the STHe PIC relative to areas of focus regarding the technical aspects of HTI/EMR implementation. The majority of work for the STHe CFS GC in FY12 will focus on Meaningful Use qualification for BH, MTMC and STH and will consist of determination of the qualification period, evaluation of the implementation strategy and assessment of program resourcing.

The Information Management Council (IMC) is the group charged with translating the strategic direction set by STHe Senior Leadership into operationally appropriate projects at both the system and facility levels by managing project charters, setting Information Systems (IS) priorities, and directing Information Technology (IT) capital/OpEx spend in accordance with strategy. This group includes a multidisciplinary group chaired by the SVP of Operations, CMIO, CIO, VP Finance/Controller, STPS CMIO, Facility COO, Facility CNO, and ad hoc members deemed necessary.

Facility-Specific Structure and Interface with System Structure

Hospital structures supporting quality, patient safety and performance improvement report to the facility's Board of Trustees through its Medical Executive Committee and to the system level through the STHe Clinical Quality Committee of the Board of Trustees, the body responsible and accountable for all quality and patient safety functions throughout Saint Thomas Health.

The functional committees supporting quality and patient safety at each facility include:

- Infection Control Committee or equivalent group

- Pharmacy and Therapeutics Committee
- Medication Safety Committee or equivalent group
- Environment of Care Committee

Quality Council (Saint Thomas Midtown Hospital and Saint Thomas West Hospital) reports to the Medical Executive Committee of each facility and is comprised of executive, hospital and medical staff leadership. Quality Council is chaired by a physician and is the primary body for review of each hospital's Quality Scorecard, containing the key metrics listed in this plan.

Each facility's Quality Council:

- Promotes leadership participation in quality efforts
- Makes recommendations for quality and performance improvement efforts
- Addresses issues regarding Joint Commission accreditation and survey preparedness
- Identifies and oversees facility-specific improvement projects
- Tracks quality indicators and improvement projects
- Provides oversight of facility quality measures

Patient Safety Council (Saint Thomas Midtown Hospital and Saint Thomas West Hospital) reports error and event data to the Q/PE to affect positive change in each facility and throughout the system. Membership is comprised of senior executives, medical staff and clinical leadership under the direction of the Quality and Risk Management department. A physician chairman acts as facilitator of Patient Safety Council meetings.

Patient Safety Council functions to:

- Review safety events including serious safety events, precursor safety events and near misses as referred by the facility's Risk Manager
- Determine the occurrence of sentinel events and review resultant root cause analyses, making recommendations for additional corrective actions as indicated
- Ensure the completion of action plans completed in response to safety events
- Review Joint Commission's Sentinel Event Alerts and issue recommendations for addressing relevant concerns
- Review aggregate patient safety data, as provided by Ascension Health, for benchmarking purposes
- Assure the completion of "Culture of Safety" assessments and review findings
- Provide multidisciplinary oversight of all patient safety functions at the facility level

Quality/Patient Safety Council (Saint Thomas Rutherford Hospital) integrates

previously-defined functions and purposes of Quality Council and Patient Safety council into a single committee.

The Clinical Assessment Committee (Saint Thomas Midtown and Saint Thomas West Hospitals) or Physician Excellence Committee (Saint Thomas Rutherford Hospital) performs multidisciplinary physician peer review at each facility, reporting to the Medical Executive Committee. The work of this committee is legally protected by TCA 63-6-219. The groups are chaired by a physician and supported by each facility's Quality Department.

The Clinical Assessment or Physician Excellence Committee:

- Adjudicates cases in which there are questions regarding standards of care
- Identifies ways to improve the quality and safety of patient care
- Analyzes how hospital and medical staff processes can be improved to eliminate the risk of recurrent error
- Ensures that physicians who are found not meeting the standard of care have access to resources, support and oversight to avoid subsequent events

- Tracks and analyzes physician practice patterns that indicate opportunity for improvement
- Recommends actions to the Medical Executive Committee
- Provides peer coaching and counseling in response to individual physician performance variances

MEC Health Information Subcommittee: is one of the primary campus specific groups at each facility charged with technical assessment of HIT and EMR functionality and its impact on patient safety, clinical quality and provider workflow. The group consists of practicing physicians from a variety of subspecialties. The physician group is supported by administrative, pharmacy, clinical informatics and IT representatives. Each campus specific MEC HIT Subcommittee meets monthly and serves as a forum for physician input on HIT implementation and provides a direct mechanism for alignment of HIT initiatives with establish medical staff governance process. The campus specific MEC HIT Subcommittees meet collaboratively on a bi-monthly basis to address the impact of HIT implementation on the dissemination of best practices and evidence based therapies across the STHe network.

VI. Performance Improvement Models

LEAN Methodology

During FY 12-13, the facilities of Saint Thomas Health have been integrating LEAN methodology into the performance improvement structure to assist in the development of solutions to complicated organizational opportunities for improvement.

In order to advance the process improvement efforts for FY14, an executive director of performance improvement position has been approved and filled. The department is currently seeking directors of PI at St. Thomas-West and St. Thomas-Midtown; St. Thomas-Rutherford currently employs a director of process and systems improvement. These positions will help to ensure the continuation of LEAN process improvements and facilitate LEAN events as new priorities are identified.

Lean and A3 Structured Problem Solving

The primary methodology for performance improvement efforts throughout the facilities of STH is the Lean process improvement methodology. The goal of any Lean event or project is transformational process change that leads directly to breakthrough process performance. In order to achieve this we will continue to train and spread the use the nine block A3 format. . Its use will ensure that a systematic approach is applied to improvement at all levels of the organization. Fundamentally, it forces the discussion for the reason for *any* action, and, although very basic, when it is overlooked or ignored, can lead to a solution that does not address the root cause. An A3 provides a clear path from current state to the desired outcome. It also provides the "lessons learned" that can be deployed along with accelerating organizational learning. The A3 platform is the preferred method for problem solving in hospital systems with highly evolved Lean cultures; some of these would include: ThedaCare, Denver Health, and Virginia Mason to name a few.

The plan for FY14 is to align the process improvement efforts with the strategic goals of the system. We will do this by developing the Transformation Plan which will consist of the strategic initiatives that executive leadership agree the Process Improvement teams at each facility will need to focus on for the fiscal year. In addition to the Transformation Plan, we will develop an Employee Engagement strategy. This will involve communicating what we are doing with regard to process improvement, why we need to improve our processes, and how associates can get involved to help build a better tomorrow.

VII. Performance Improvement Tools

The facilities of Saint Thomas Health use tools and instruments common to quality improvement processes and include:

- Flow-charting
- Brainstorming
- Nominal group technique
- Multi-voting
- Affinity diagrams
- Cause-and-Effect diagrams
- Histograms
- Pareto charts
- Run charts
- Control charts
- Benchmarking
- Root cause analysis
- Apparent cause analysis
- Common cause analysis

A description of each of these tools and the manner in which they may be used if found in Addendum C of this plan.

VIII. Annual Evaluation of Quality and Patient Safety Plan

A comprehensive review of quality and patient safety activities is conducted annually at the system and facility level through review of quality scorecards as well as other reports, findings and audits that have been collected throughout the past twelve months.

New priorities, initiatives, goals and expected outcomes are identified as previously described in this plan.

Each facility is responsible for evaluating its internal quality and patient safety program, including intersects with contracted services.

Tab 18

Attachment C
Contribution to the Orderly Development of Health Care – 5

Utilization Review Plan

Baptist Hospital
Nashville, Tennessee

Title: Utilization Review Plan	**Policy #:**
Developed By: Richard A. Orland, M.D. Medical Advisor Care Management Program	**Date: April 26**, 2013
Approved By:	**Date:**
Reviewed:	**Revised:**
Scope: Hospital – Wide	**Written:**

I. AUTHORITY (Title 42 Code of Federal Regulations 456.105)

Ultimate responsibility for the quality, appropriateness and clinical necessity of admissions, continued stays, and supportive services rests with the Saint Thomas Health (STHe) Board of Directors. The STHe Board of Directors authorizes the Baptist Hospital Medical Staff and Hospital Administration to demonstrate and promote effective and efficient patient care through the implementation of a Utilization Review (UR) plan.

II. RESPONSIBILITY

The Board of Directors, Chief Executive Officer of Baptist Hospital, and the Chief of the Medical Staff assigns and empowers the Utilization Review Committee (URC) to implement the Utilization Management Plan to support the hospital's mission and vision through collection and review of data that assures the appropriate allocation of hospital resources.

III. PURPOSE

The purpose of this UR plan is:

A. To assure effective and efficient utilization of available hospital facilities and services consistent with patient needs and professionally recognized standards of healthcare.
B. To identify opportunities for changes needed to maintain high quality and appropriate patient care, as well as identify over and under utilization of resources, quality related issues, and/or risk related issues.
C. To assure that documentation in the medical record substantiates the quality and utilization of services needed in the management and progress of every patient.

IV. ORGANIZATION (42 CFR 456.105, 106, 112 & 113)

A utilization review committee (URC) shall be established at Baptist Hospital to carry out the utilization review plan. It may be titled differently, i.e., "Clinical Resource Committee." The URC shall report all significant issues, findings and recommendations to the Medical Executive Committee at least annually, as evidenced in the Medical Executive Committee's minutes. It is the ultimate responsibility of the Board of Directors and Medical Staff to facilitate the efforts of the URC by providing assistance and direction in the process of implementing and/or maintaining

quality patient care.

A. Membership and Structure (A-0310 482.30, 217)

i. Either the Chief Medical Officer (CMO) or a physician committee member appointed by the CMO or Chief or Staff will serve as Chair of the URC. The Chair will make himself/herself available to facilitate and assist the Medical Advisor, Care Management, as need arises.

ii. Physician members who are part of the Baptist Hospital Medical Staff and who represent various medical staff departments shall be appointed by the CMO with assistance and input from the Chair and Medical Advisor. In addition to the Medical Advisor, a minimum of two practicing physicians shall serve on the URC. All Baptist Hospital Medical Staff physician members, including the Medical Advisor, will have voting privileges.

iii. Non-physician, non-voting members may include representatives from such areas as administration, care management, Clinical Integration, access/bed management, HIM, performance improvement, and Compliance. Other health care practitioners may be asked to serve as consultants to the committee and may be requested to attend meetings on an "as needed" basis.

iv. The Utilization Review Committee will meet as deemed necessary by the Chair, but at least four (4) times each calendar year. A quorum will be 33% of the URC physician membership.

v. The URC shall keep minutes of all meetings. The minutes shall summarize significant discussions, findings, and actions taken as a result of URC decisions or recommendations. Minutes, information, and data used by the URC will be maintained as peer review records including any findings or recommendations as required to assure confidentiality and compliance with all laws and regulations.

vi. The URC authorizes the Medical Affairs, Clinical Integration, Care Management, Finance, and HIM Departments to provide support services as needed for the performance of the URC.

vii. The URC recognizes the authority of the State QIO(s) in their role as to any assessment and monitoring of review activities.

viii. Per Tennessee Code Annotated (TCA) 63 – 6 – 219, data generated or utilized by the UR Committee will be maintained in confidence and secured to the fullest extent possible to protect from loss, defacement, tampering, or use by unauthorized persons. Information which identifies an individual or practitioner is considered privileged except for that information which is necessary to facilitate the review program by fiscal intermediaries and state agencies for payment of claims. Exceptions will be granted to other outside agencies only through signed, written agreements with the hospital or as required by law.

B. Condition of membership and conflict of interest (A-0310 482.30, section 3, 218)

i. All physician members of the committee shall serve renewable one-year memberships. Members are expected to attend at least 50% of scheduled meetings. The CMO, with the approval by the Chair of the URC, shall be responsible for appointing members to fill vacancies.

ii. No physician member shall have review responsibility for any case in which s/he had, has, or expects to have clinical involvement.

iii. No committee member shall have a direct financial interest, as defined by the Social Security Administration, in Baptist Hospital.

C. Responsibilities (A-0311 482.30)

i. To establish and carry out a review program in accordance with applicable state, federal and payer rules and requirements.

ii. To obtain, review and evaluate information generated by the hospital's Care Management program, Clinical Integration, and other departments. This may include information regarding:

a. Comparative data of physician specialties, services lines, DRGs, and individual physicians with respect to ALOS and charges/costs per case;
b. Denied days of care or denied costs of care received from third party payers specific to lack of precertification, medical necessity, or quality of care;
c. Average length of stay and Case Mix Index;
d. Numbers of cases that were sent to second-level physician review;
e. Case manager interventions related to days/costs saved
f. Avoidable days specific to obstacles that delay the progress of care or delivery of care and which may compromise the safety of patients and the quality of care
g. Other data and information pertaining to resource utilization and management as determined by the committee to be part of the agenda of each meeting.

Such information and measures will be reported to the URC during scheduled meetings.

iii. Along with Care Management Program staff, to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, and use of medical or hospital services, which may contribute to under- or over-utilization of services when indicated by the data.

iv. To review selected cases that with extended length of stay, extraordinarily high costs and/or excessive physician services as detected by Care Management Program staff as no longer meeting screening criteria for continued care at the inpatient level of care

v. To refer individual cases, where there is a concern regarding the quality of patient care, to the appropriate hospital or medical staff department.

vi. Participate in educational initiatives for physicians and other caregivers regarding the stewardship of healthcare resources.

vii. To adopt and modify review criteria and standards as needed and recommend changes in hospital procedures or medical staff practices that are identified by an analysis of review findings.

viii. To determine that point during any specific patient's hospitalization at which Medicare, Medicaid, and Title V Programs, and other third party payers should have no further financial

responsibility for the patient because of lack of medical need. The attending physician has the right to have the case reviewed by the URC and the QIO in the case of federally funded cases.

ix. To maintain liaison with the quality improvement and risk management functions in order to coordinate the findings of the program.

x. To provide utilization information, as requested, for credential review files.

xi. To review the Utilization Review plan annually and make recommendations regarding such to the CMO and URC Chair for revision.

V. METHODS AND TYPES OF REVIEW (42 CFR 456.121, 131)

Utilization review consists of a pre-admission and/or admission certification, appropriateness of continued stay and discharge readiness. These determinations, using standard criteria sets, physician documentation, observations, and/or conversations with the attending physician are performed by Care Management Program staff.

Reviews may be focused on certain selected diagnoses and procedures with identified or suspected utilization related problems, regardless of payer type. All reviews will address over- and under-utilization as well as ineffective use and scheduling of resources.

A. Preadmission review (42 CFR 456.127)

i. On selected occasions, review and final decision prior to the patient's admission may be accomplished for certain providers or categories of admission identified by the URC and/or Care Management Program staff as potential utilization issues. This may include patients accessing inpatient services through the emergency department, direct admits and/or transfers from other facilities.

ii. If the pre-admission review does not meet established criteria, the case will first be discussed with the attending physician to explore alternate level of care services and, if necessary, forwarded to the Medical Advisor, Care Management Program.

iii. If needed, the case is elevated to the applicable physician chief of the particular service or the CMO; if necessary, a Hospital Issued Notice of Non-Coverage (HINN) letter is issued to the patient before he/she is formally admitted to the hospital and the hospital has reason to believe the admission will not be covered by Medicare or other payer.

B. Admission review (42 CFR 456.60, 4565.121 - 126 & 129)

i. All inpatient admissions shall be reviewed for appropriateness for inpatient level of care by a two-level process. Initial first level case review will be at the screening level and is to be performed by Care Management Program staff for appropriate level of care and appropriate plan of care, based on screening criteria (such as InterQual).

ii. In cases of seemingly non-qualified admission, once the initial screening criteria are applied, the Medical Advisor or another physician will provide second-level medical/physician review. Such physicians may be other physicians on the URC, non-URC physicians on the medical staffs of hospitals in the STHe system, and/or

other non-URC physician advisors of external resources and vendors.

C. Continued stay (42 CFR 456.128 - 137)

i. Continued stay reviews are based on established guidelines, such as those developed by "Interqual" criteria.

ii. A more focused review may be used for cases that, by experience, have been associated with high cost, frequent use of excessive services, or are attended by a physician whose patterns of care have caused quality of care or safety concerns.

iii. If continued stay appears inappropriate, the utilization review specialist or case manager will consult with the Care Management Program staff and/or the attending physician and discuss discharge readiness and alternate levels of care and services. If necessary, the Medical Advisor of the Care Management Program or other designated physicians will be consulted and perform second-level review.

iv. If needed, the case is elevated to the attention of the applicable physician chief of service or the CMO; if necessary, a Hospital Issued Notice of Non-Coverage (HINN) letter is issued to the patient per direction of the URC.

D. Second Level Physician Review for Inpatient Level of Care

i. If the Care Management Program case management staff determine by first-level screening criteria that a patient's inpatient admission is not appropriate or continuing care is no longer consistent with medical management at the in-patient level, the case will be referred to the hospital's Utilization Review Committee or a subgroup thereof, which contains at least one (1) physician member of the URC, which may be the Medical Advisor of the Care Management Program. or other designated physicians and/or physician advisors.

Second level reviews performed by physicians who are not on the Utilization Review Committee will be considered as advisory in nature. A physician member of the URC must review and agree with all reviews performed by non-URC physician members. The judgment and recommendation of the URC member shall be the action taken.

In the latter event of such second-level physician review, if the physician performing second-level review has reason to believe the admission or continued stay is not necessary or no longer medically appropriate at the in-patient level, he/she will attempt to contact the attending physician and afford him/her an opportunity to discuss the case or situation in question. In such situations, the attending physician's judgment and opinion is given considerable weight. If the attending physician concurs that inpatient admission is not appropriate or medical necessity for continued stay does not exist, the attending physician will treat the patient at a lower level of care or discharge the patient. In the situations where inpatient admission is not appropriate, the Hospital shall follow the procedures applicable for Condition Code 44 or the applicable denial of benefits procedure.

ii. If, however, the attending physician does not concur with the determination made by the Medical Advisor or other physician member of the UR Committee, the case

will be referred to at least one other physician member of the Utilization Review Committee for case review. In such situations, the attending physician's judgment is once again given considerable weight. If this additional second physician review indicates justification for admission/ continued stay, the admission or continued stay will be deemed medically appropriate.

If the two physician members determine that the patient's inpatient admission/stay is not medically necessary or appropriate, their determination becomes final, and the attending physician shall be informed of such; the Hospital follows the applicable denial of benefits procedure or the procedures applicable for Condition Code 44. The determination of the URC member(s) shall be documented in the patient's record.

It should be noted that in such situations, Hospital care is not being denied, however, the patient (and/or insured) will be informed of any potential financial liability for non-covered services. The Director of Care Management or designee will provide written notice of such to the patient and/or patient representative when the determination is made that the patient's care is not appropriate at the inpatient level. Copies will be distributed to the hospital, the state agency for Medicare patients (if applicable), the attending physician and any other appropriate reviewing organization no later than 2 days after such final decision.

E. Extended Stay Reviews

Cases of long length of stay and/or high cost will also be reviewed by a two-level process. Initial first level case review will be at the screening level and is to be performed by Care Management Program staff for appropriate level of care and appropriate plan of care, based on screening criteria (such as InterQual).

If continued stay appears inappropriate, the utilization review specialist or case manager will consult with the Care Management Program staff and/or the attending physician and discuss discharge readiness and alternate levels of care and services. If necessary, the Medical Advisor of the Care Management Program or other designated physicians will be consulted and perform second-level review.

The procedures for second-level physician review as specified in **V. D** above ("Second Level Physician Review for Inpatient Level of Care") shall apply for such extended stay reviews.

F. Discharge Readiness

i. Early discharge planning is an important aspect in the efficient use of available health care services and in the protection of our patients against the risks of hospitalization. The case manager is responsible for coordinating the efforts of the multidisciplinary team for planning a patient's discharge. In order to facilitate and accomplish a smooth and safe discharge from acute care to the appropriate level, the attending physician will work in conjunction with the Case Manager and staff of the Care Management Program to assure that post-acute care needs have been addressed by the time discharge occurs.

VI. PATIENT INFORMATION REQUIRED FOR UTILIZATION REVIEW

Each patient's record must include specific information needed to efficiently perform the UR function. This information shall include, but not be limited to accurate identification of the patient; name of the patient's attending physician; name of the patient's third party insurer (when applicable); date of admission; the documented plan of care; date of operation or procedure; the justification of an emergency admission (when applicable); and other supporting documentation that the URC believes appropriate to be include for the determination process.

VII. ACCEPTANCE AND APPROVAL

_____ _____

Chairman, Medical Executive Committee

_____ _____

President, Chief Executive Officer

Reference: Code of Federal Regulations Title 42, Part 456 and Part 482

Written: March 6, 2007
Revised: May 20, 2007
June 22, 2007
July 11, 2007
April 23, 2009
July 27, 2009
February 19, 2012
March 26, 2012

April 26, 2013

Tab 19

Attachment C
Contribution to the Orderly Development of Health Care – 5

Patient Bill of Rights

Saint Thomas Health

Effective Date:	*04/2013*
Last Reviewed:	*04/2013*
Last Revised:	*04/2013*
Expiration Date:	*04/2016*
Owner:	*Thompson, Dr. Bill: Chief Quality Officer*
Section/Dept:	*Rights and Responsibilities of the Individual*
References:	
Applicability:	*Saint Thomas Health*

Patient Rights and Responsibilities

Hospital care is a special partnership between patients, their loved ones, physicians and hospital staff. We at Saint Thomas Health respect your rights, values and dignity, and we ask that you recognize the responsibilities that come with being a patient in our hospitals. Please review these rights and responsibilities and discuss them with your caregivers and your family.

PATIENT RIGHTS:

- You have the right to safe, high quality, compassionate healthcare, without fear of discrimination of any kind.
- You have the right to the most appropriate medical treatment available, delivered in a safe, considerate, and respectful manner.
- You have the right to have your illness, treatment, alternatives and outcomes explained in a manner and language you can understand, including the use of interpretation services as needed.
- You or your personal representative has the right to participate in the development and implementation of your plan of care.
- You have the right to make informed decisions about your care in collaboration with your physician and other caregivers. You have the right to accept or refuse medical care, including life sustaining and resuscitative treatment, to the extent permitted by law. You have the right to be informed of the medical consequences of your decisions.
- You have the right to receive professional assessment and management of your pain.
- You have the right to know the identity and professional status of persons caring for you, and the right to refuse to be treated by a student. You have a right to request a second opinion.
- You have the right to complete, ongoing information concerning your diagnosis, treatment, and any known prognosis. You have the right to information on post-discharge care needs and alternatives, including transfers to another facility.
- You have the right to assistance with and to participate in the consideration of ethical issues that may arise in the course of your care.
- You have the right to know what hospital rules and regulations apply to you as a patient
- You have the right to refuse experimental treatment or drugs.
- You have the right to private and confidential treatment/personal care, communications and medical records to the extent permitted by law.
- You have the right to have information regarding your medical treatment explained to your family member or other appropriate individual when you are unable to participate in decisions about your care.
- You have the right to receive information about and assistance with advance directives, (Living Will/ Advance Care Plan; Durable Power of Attorney for Healthcare/ Surrogate Decision Maker for Healthcare/ Physician Orders for Scope of Treatment), which may include delegation of the right to make decisions about your care to a personal representative, as well as designation of a support person. You have the

right to review and revise existing directives, and to have your advance directives respected within the limits of the law.

- You have the right to have your wishes regarding organ donation honored. You have the right to have your treatment preferences honored and to receive the same level of care whether or not you have written advance directives.
- You have the right to access the information in your medical records within a reasonable timeframe. You have the right to request amendments to your medical record. You have the right to receive an accounting of disclosures of your medical information, within the limits of the law.
- You have the right to examine an itemized copy of your hospital bill and to have it explained to you, regardless of source of payment. You also have the right to information concerning possible resources for financial assistance.
- You have the right to care that is provided in the least restrictive way, and to have restrictions such as restraints or seclusion explained and reviewed.
- You have the right to be free from all forms of abuse, neglect and exploitation, and the right to access protective or advocacy services when indicated or required.
- You (or your support person) have the right to be informed of your visitation rights including any clinical restrictions or limitations of our rights.
- You have the right to receive visitors designated by you, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Also included is the right to withdraw or deny such consent at any time.
- You have the right to visitation privileges that are not restricted, limited, or denied based upon race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. All your visitors shall enjoy full and equal visitation privileges.
- You have the right to the presence of a support individual of your choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be your surrogate decision maker or legally authorized representative.

PATIENT RESPONSIBILITIES:

- You are responsible for providing the hospital with all necessary information about your medical history, hospitalizations, medications, and other matters related to your health.
- You are responsible to communicate with those involved in your care, including asking questions if medical information or instructions are not clear to you.
- You are responsible for following your plan of care. If you are unable or unwilling to follow the plan of care, you are responsible for telling your care provider. Your care provider will explain the medical consequences of not following the recommended treatment. You are responsible for the outcomes of not following your plan of care.
- You are responsible to respect your caregivers' efforts to provide care and treatment to other patients.
- You are responsible for following the hospital's rules and regulations, to act in a manner that is respectful of other patients, staff and hospital property, and to ask that your visitors do the same.
- You are responsible to provide the hospital with a copy of your advance directive, and to inform your family or preferred decision maker about your wishes and the location of any advance directives.
- You are responsible to provide the hospital with financial and health insurance information necessary to process your bill, and to meet your financial obligations to this facility.

COMPLAINT RESOLUTION:

We want to hear from you. You and your family have the right to voice your compliments, concerns and complaints freely without fear of coercion, discrimination, reprisals, or unreasonable interruptions of care. Your concerns and complaints will be reviewed and resolved when possible, and grievances will be responded to within seven (7) working days. You may voice your concerns with your caregivers, or you may call one of the following Complaint Lines:

Saint Thomas Hickman Hospital (931) 729-4271
Saint Thomas Midtown Hospital (615) 284-4438
Saint Thomas Rutherford Hospital (615) 396-5934
Saint Thomas West Hospital (615) 222-6630

If you do not feel your complaint was handled properly, please call one of the following numbers:

Tennessee Department of Health, Health Facilities Complaint Hotline 1-877-287-0010
Joint Commission Complaint Hotline 1-800-994-6610

All revision dates:	04/2013
Attachments:	No Attachments

Tab 20

Attachment C
Contribution to the Orderly Development of Health Care - 7.(b)

The Joint Commission Documentation

The Joint Commission

October 20, 2011

Bernard Sherry, BS, MHA
CEO/President
Baptist Hospital
2000 Church Street
Nashville, TN 37236

Joint Commission ID #: 7884
Program: Hospital Accreditation
Accreditation Activity: Measure of Success
Accreditation Activity Completed: 10/20/2011

Dear Mr. Sherry:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning April 09, 2011. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the Centers for Medicare and Medicaid Services (CMS), state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Ann Scott Blouin RN, PhD

Ann Scott Blouin, RN, Ph.D.
Executive Vice President
Accreditation and Certification Operations

Tab 21

Attachment C
Contribution to the Orderly Development of Health Care - 7.(c)

Hospital License

Board for Licensing Health Care Facilities

State of Tennessee

0000000032

No. of Beds 0623

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

SAINT THOMAS MIDTOWN HOSPITAL *to conduct and maintain a*

Hospital SAINT THOMAS MIDTOWN HOSPITAL

Located at 2000 CHURCH STREET, NASHVILLE

County of DAVIDSON *, Tennessee.*

This license shall expire APRIL 30 *,* 2014 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 30TH *day of* APRIL *,* 2013 *.*

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By [signature]
COMMISSIONER

000257

ICF011

Tab 22

Attachment C
Contribution to the Orderly Development of Health Care -7.(d)

Inspection Report

FAX TRANSMITTAL

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH CARE FACILITIES

TO: Bernard Sherry, Administrator

FACILITY: Baptist Hospital

FAX NUMBER: 615-284-1592 PHONE: 615-284-6851

FROM: Karen B. Kirby, Regional Administrator – HCF, ETRO by KG

FAX NUMBER: (865) 594-5739

DATE: September 12, 2012

NUMBER OF PAGES INCLUDING THIS ONE: 9

IF YOU HAVE ANY QUESTIONS, CALL (865) 588-5656

SUBJECT/MESSAGE: **COMPLAINT(S) # TN00030295**

Original to follow by mail. If you have any questions regarding your statement of deficiencies please call for a supervisor @ 865-588-5656.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

September 12, 2012

Mr. Bernard Sherry, Administrator
Baptist Hospital
2000 Church St
Nashville TN 37236

Provider Number: 44-0133

Dear Mr.Sherry:

Enclosed is the Statement of Deficiencies developed as the result of the complaint investigation conducted at the Baptist Hospital on **September 4, 2012.** You are requested to submit a Plan of Correction by **September 22, 2012** with acceptable time frames for correction of the cited deficiencies. Corrective action must be achieved prior to **October 19, 2012.** Please notify this office when these deficiencies are corrected.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

Please submit the Plan of Correction (POC), by **September 22, 2012:**

Office of Health Licensure and Regulation
Lakeshore Park, Bldg. One
5904 Lyons View Pike
Knoxville, TN 37919

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice.
- How you will identify other residents/patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored and the person(s) responsible for monitoring to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Please put your Plan of Correction on the Statement of Deficiencies form in the "Provider's Plan of Correction" column. In the "Completion Date" column of the form, list the date corrective actions have been or will be completed. Please make sure the administrator's signature and date are on the bottom line of the Statement of Deficiencies/Plan of Correction State Form.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If you have any questions, please contact this office at (865) 588-5656 or by facsimile at (865) 594-5739.

Sincerely,

Karen B. Kirby/mad

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

Enclosure: CMS-2567

TN00030295

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440133	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the nursing staff educated patients adequately before discharge for one (#3) of five patients reviewed. The findings included: Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...". Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID	A 395		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 395	Continued From page 1 (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4,	A 395		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 395	Continued From page 2 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 395		
A 820	482.43(c)(3), (5) IMPLEMENTATION OF A DISCHARGE PLAN (3) The hospital must arrange for the initial implementation of the patient's discharge plan. (5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to develop an appropriate discharge plan to meet the needs of patients for one (#3) of five patients reviewed. Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...", Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units	A 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 820	Continued From page 3 each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin	A 820		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440133	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 820	Continued From page 4 administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4, 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 820		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53132	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	1200-8-1 Initial During complaint investigation of #30295, conducted on September 4, 2012, at Baptist Hospital, no deficiencies were cited in relation to the complaint under 1200-8-1, Standards for Hospitals.	H 001		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Tab 23

Attachment C
Contribution to the Orderly Development of Health Care -7.(d)

Plan of Corrective Action

FAX TRANSMITTAL

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH CARE FACILITIES

TO: Bernard Sherry, Administrator

FACILITY: Baptist Hospital

FAX NUMBER: 615-284-1592 PHONE: 615-284-6851

FROM: Karen B. Kirby, Regional Administrator – HCF, ETRO by KG

FAX NUMBER: (865) 594-5739

DATE: September 12, 2012

NUMBER OF PAGES INCLUDING THIS ONE: 9

IF YOU HAVE ANY QUESTIONS, CALL (865) 588-5656

SUBJECT/MESSAGE: **COMPLAINT(S) # TN00030295**

Original to follow by mail. If you have any questions regarding your statement of deficiencies please call for a supervisor @ 865-588-5656.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

September 12, 2012

Mr. Bernard Sherry, Administrator
Baptist Hospital
2000 Church St
Nashville TN 37236

Provider Number: 44-0133

Dear Mr.Sherry:

Enclosed is the Statement of Deficiencies developed as the result of the complaint investigation conducted at the Baptist Hospital on **September 4, 2012.** You are requested to submit a Plan of Correction by **September 22, 2012** with acceptable time frames for correction of the cited deficiencies. Corrective action must be achieved prior to **October 19, 2012.** Please notify this office when these deficiencies are corrected.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

Please submit the Plan of Correction (POC), by **September 22, 2012:**

Office of Health Licensure and Regulation
Lakeshore Park, Bldg. One
5904 Lyons View Pike
Knoxville, TN 37919

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice.
- How you will identify other residents/patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored and the person(s) responsible for monitoring to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Please put your Plan of Correction on the Statement of Deficiencies form in the "Provider's Plan of Correction" column. In the "Completion Date" column of the form, list the date corrective actions have been or will be completed. Please make sure the administrator's signature and date are on the bottom line of the Statement of Deficiencies/Plan of Correction State Form.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If you have any questions, please contact this office at (865) 588-5656 or by facsimile at (865) 594-5739.

Sincerely,

Karen B. Kirby/mad

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

Enclosure: CMS-2567

TN00030295

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440133	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the nursing staff educated patients adequately before discharge for one (#3) of five patients reviewed. The findings included: Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...". Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID	A 395	For current and future patients new triggers have been added to our computerized medical record system which triggers an individualized care plan to include diabetes education and insulin education based on individual experience with insulin use. As for patients that may have been affected in the past, a random audit of known diabetics over the past six months will be conducted seeking patients who have been discharged with new prescriptions of insulin. Five per month will be examined unless the total new insulin patients is less then 5 in a given month. If documented education is not found, patients will be given appointments with the Diabetes Center for education at no charge. Education for all nurses regarding individualizing care plans for diabetics is in process (began 9/28/12) with extended deadline to cover nurses who may be on leave of absence.	9/25/12 10/19/12 11/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440133	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

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A 395	Continued From page 1 (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4,	A 395	Concurrent audits of diabetic patients by the Diabetes center nurses for a period of six months. Audits will include monitoring care plans, will be reviewed monthly by Kathie Hirsch, CNO and Deborah Roberts, Director, Quality/Risk. Discharge planning for patients regarding diabetes will be initiated with admission assessment and will be incorporated within the care plan including insulin teaching for the patient, significant others, and home caregivers. This will include return demonstrations. Depart process includes triggers for education of patients and significant others regarding injectable insulin including return demonstration and written materials to take home. The Diabetes Center nurses are also available to assist.	10/8/12 - 4/8/2013 9/25/12 9/25/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 395	Continued From page 2 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 395		
A 820	482.43(c)(3), (5) IMPLEMENTATION OF A DISCHARGE PLAN (3) The hospital must arrange for the initial implementation of the patient's discharge plan. (5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to develop an appropriate discharge plan to meet the needs of patients for one (#3) of five patients reviewed. Medical record review revealed patient #3 was admitted to the facility on July 26, 2012, with complaints to include Shortness of Breath which had increased over the past week. Pertinent medical history included diagnoses of Hypertension, Diabetes Mellitus, Parkinson's Disease, Ulcerative Colitis, Obstructive Sleep Apnea, Depression, and Panic Disorder. Review of the History and Physical completed by the physician on July 26, 2012, revealed the patient had "...Diabetes Mellitus uncontrolled...". Review of physician's admission orders written on July 26, 2012, revealed "...Lantus insulin 15 units	A 820	Education for all nurses regarding diabetic patient discharge instructions, return demonstration of insulin administration by patient and significant other is currently in process and will be extended to allow for nurses on leave of absence. Concurrent audits by Diabetes Center nurses regarding depart diabetes education, return demonstration if going home with new injectable insulin prescriptions for a period of 6 months. Will be reviewed monthly by Kathie Hirsch, CNO and Deborah Roberts, Director, Quality/Risk.	11/30/12 10/8/12 - 4/8/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 820	Continued From page 3 each evening; accu checks (blood glucose monitoring) before meals and at bedtime; and sliding scale insulin (specific doses of insulin according to the blood glucose range) with each accu check...". Further review of physician's orders dated July 26, 2012, at 11:27 p.m., revealed "...hold PM dose of Lantus (insulin)...". Continued review of physician's orders dated July 27, 2012, at 7:30 a.m., revealed "...Lantus 10 units at bedtime; Novolog (insulin) 3 units TID (three times daily) before meals...". Review of Education notes dated July 26, 2012, at 4:59 p.m., revealed "...Diabetes Standards of Care: Given to/Reviewed with Patient and/or Caregiver...". Further review of the education notes dated July 26, 2012, at 8:00 p.m., revealed patient and family were taught via demonstration about "...blood glucose testing and when; blood glucose testing goals; hypoglycemia (low blood glucose) signs and symptoms and treatment; medication: oral/insulin/other...". Further review of education notes revealed no documentation there was a return demonstration by the patient of correct insulin administration. Review of discharge medications dated August 1, 2012, revealed the patient was ordered ..."Lantus insulin 10 units once daily at bedtime; Novolog insulin three times daily before meals and at bedtime, medium sliding scale as instructed...". Interview with the Nurse Manager of Cardiology, the unit where the patient was admitted, on September 4, 2012, at 11:15 a.m. in the Risk Management conference room, revealed the spouse stated, at discharge, the patient had not received proper education regarding insulin	A 820		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 820	Continued From page 4 administration. Further interview revealed the hospital has a contract with the Diabetes Center to provide education to patients but the center was not consulted on this patient. Continued interview confirmed there was no nursing documentation the patient had been educated on insulin administration and calculating dosages of sliding scale insulin before discharge." Interview with the Risk Manager on September 4, 2012, at 12:30 p.m., in the Risk Management office, confirmed the patient did not receive education on insulin administration and calculating dosages on the sliding scale.	A 820	Diabetes Center was not asked to consult on this patient. Normal triggers for diabetes educators include blood sugars >180 and A1C >8. Neither applied in this situation. The electronic medical record system will now include a prompt for nursing to consult Diabetes Educator if necessary to ensure all patients are evaluated and educated.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP53132	A. BUILDING _____ B. WING _____	C 09/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOSPITAL	2000 CHURCH ST NASHVILLE, TN 37236

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H 001	1200-8-1 Initial During complaint investigation of #30295, conducted on September 4, 2012, at Baptist Hospital, no deficiencies were cited in relation to the complaint under 1200-8-1, Standards for Hospitals.	H 001		

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

October 31, 2012

Mr. Bernard Sherry, Administrator
Baptist Hospital
2000 Church St
Nashville TN 37236

RE: 44-0133

Dear Mr. Sherry:

The East Tennessee Region of Health Care Facilities conducted a complaint investigation on September 4, 2012. A desk review was conducted, based on that review; we are accepting your plan of correction and are assuming that your facility is in compliance with all participation requirements as of October 19, 2012.

If you have any questions, please contact the East Tennessee Regional Office by phone: 865-588-5656 or by fax: 865-594-5739.

Sincerely,

Karen B. Kirby/kg

Karen B. Kirby, RN
Regional Administrator
East TN Health Care Facilities

KK: kg

TN00030295

Attachment D

Copy of Published Public Notice
Letter of Intent

Tab 24

Attachment D

Copy of Published Public Notice

Space heaters; Catnapper power lift recliner & sofa-recliner, vintage Kenmore sewing machine & table, W/D, fridge, many appls (Oreck, Rowenta, Keurig), glassware, kitchenware & more
PIX & DIRECTIONS: EstateSales.net

Estate Sales - Montgomery

ESTATE SALE
CLARKSVILLE TN 37040
1124 MADISON ST.
Thurs. Jan. 9, 8-4pm
Fri. Jan. 10, 8-4pm
Sat. Jan. 11, 8-3pm
DON'T MISS IT!
3 Days of Bargains on 3½ Acres of Property!
Selling the life estate of J.S. Batson, a well known Clarksville dentist. This gentlemen was a farmer, mechanic, plumber, fisherman, avid collector as well as a dentist.
Selling antiques, pottery, tools of all sorts, vintage dental equip., old boat, furn., glassware, collectibles, jewelry, home decor, books, appliances, clothing, contents of a 3 car garage & basement.
If you are a scrap metal collector, be there early! Several loads of scrap items available.
YOU'VE SEEN THE SIGN DOZENS OF TIMES - IT'S ALL HAPPENING AT TOOTH ACRES!

MICHAEL TAYLOR
Estate/Moving Sales
Accepting Credit Cards, Cash & Checks
FOR PIX & DIRECTIONS: EstateSales.net
YOUR ESTATE LIQUIDATION SPECIALISTS

Garage Sales - Rutherford

REMEMBER WHEN ANTIQUES & COLLECTIBLES
Red Tag Sale on certain items. Drop in and check out our wonderful treasures & original paintings by Oliver Langston.
Sale runs thru January 25.
121 FRONT ST., SMYRNA

0101710290

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Saint Thomas Midtown Hospital, an existing acute care hospital owned by Saint Thomas Midtown Hospital with an ownership type of not-for-profit and to be managed by Saint Thomas Midtown Hospital intends to file an application for a Certificate of Need for the renovation of surgical suites, patient care areas and support space for the realignment and consolidation of total joint replacement services at Saint Thomas Midtown Hospital, located at 2000 Church Street, Nashville, Tennessee. The total number of licensed beds at Saint Thomas Midtown Hospital will not change as a result of this project. Renovations will be made to 94,337 square feet of space and there will be no new construction. The total project costs are estimated to be $25,832,609.

The anticipated date of filing the application is: January 15, 2014. The contact person for this project is Barbara Houchin, Executive Director, Planning, who may be reached at Saint Thomas Health, 102 Woodmont Blvd., Suite 800, Nashville, Tennessee, 37205, 615-284-6849.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

This sale is subject to all matters shown on any applicable recorded plat; any unpaid taxes; any restrictive covenants, easements, or setback lines that may be applicable; any statutory rights of redemption of any governmental agency, state or federal; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. In addition, the following parties may claim an interest in the above-referenced property: Anthony L. Williams; Jennifer M. Williams; Mortgage Electronic Registration System as nominee for Mila, Inc.; America's Servicing Company; Atlantic Credit & Finance LLC; MILA, Inc; Deutsche Bank National Bank Trust Company; Ford Motor Credit Company; Anthony L. Williams; Tennessee Office of Child Support; State Farm Mutual Automobile Insurance Company; Wells Fargo Bank,N.A d/b/a America's Servicing Company

The sale held pursuant to this Notice may be rescinded at the Successor Trustee's option at any time. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above. **W&A No. 1286 129174**

DATED December 31, 2013

closure sale, the entire purchase price is due and payable at the conclusion of the auction in the form of a certified/bank check made payable to or endorsed to Shapiro & Kirsch, LLP. No personal checks will be accepted. To this end, you must bring sufficient funds to outbid the lender and any other bidders. Insufficient funds will not be accepted. Amounts received in excess of the winning bid will be refunded to the successful purchaser at the time the foreclosure deed is delivered.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time.

Shapiro & Kirsch, LLP Substitute Trustee
www.auction.com
Law Office of Shapiro & Kirsch, LLP
555 Perkins Road Extended, Second Floor
Memphis, TN 38117
Phone (901)767-5566
Fax (901)761-5690
File No. 13-054372

0101710097

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on **March 13, 2014 at 1:00PM local time**, at the East Entrance inside the Lobby of the Main Floor door Sumner County Courthouse, 100 Public Square Gallatin, Tennessee pursuant to Deed of Trust executed by Daniel W. Hopkins

Tab 25

Attachment D

Letter of Intent

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

RECEIVED
JAN 15 2014
HSDA

LETTER OF INTENT

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson (County), Tennessee, on or before January 10 (Month / day), 2014 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Saint Thomas Midtown Hospital, (Name of Applicant) an existing acute care hospital (Facility Type-Existing)

owned by: Saint Thomas Midtown Hospital with an ownership type of not-for-profit and to be managed by: Saint Thomas Midtown Hospital intends to file an application for a Certificate of Need for: the renovation of surgical suites, patient care areas and support space for the realignment and consolidation of total joint replacement services at Saint Thomas Midtown Hospital, located at 2000 Church Street, Nashville, Tennessee. The total number of licensed beds at Saint Thomas Midtown Hospital will not change as a result of this project. Renovations will be made to 94,337 square feet of space and there will be no new construction. The total project costs are estimated to be $25,832,609.

The anticipated date of filing the application is: January 15, 2014

The contact person for this project is Barbara Houchin (Contact Name) Executive Director, Planning (Title)

who may be reached at: Saint Thomas Health (Company Name) 102 Woodmont Blvd., Suite 800 (Address)

Nashville (City) Tennessee (State) 37205 (Zip Code) 615-284-6849 (Area Code / Phone Number)

Barbara Houchin (Signature) January 10, 2014 (Date) bhouchin@sth.org (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

2014 JAN 10 PM 1:32

LETTER OF INTENT

The Publication of Intent is to be published in the Tennessean (Name of Newspaper) which is a newspaper of general circulation in Davidson (County), Tennessee, on or before January 10 (Month / day), 2014 (Year), for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Saint Thomas Midtown Hospital, (Name of Applicant) an existing acute care hospital (Facility Type-Existing)

owned by: Saint Thomas Midtown Hospital with an ownership type of not-for-profit and to be managed by: Saint Thomas Midtown Hospital intends to file an application for a Certificate of Need for: the renovation of surgical suites, patient care areas and support space for the realignment and consolidation of total joint replacement services at Saint Thomas Midtown Hospital, located at 2000 Church Street, Nashville, Tennessee. The total number of licensed beds at Saint Thomas Midtown Hospital will not change as a result of this project. Renovations will be made to 94,337 square feet of space and there will be no new construction. The total project costs are estimated to be $25,832,609.

The anticipated date of filing the application is: January 15, 2014

The contact person for this project is Barbara Houchin (Contact Name) Executive Director, Planning (Title)

who may be reached at: Saint Thomas Health (Company Name) 102 Woodmont Blvd., Suite 800 (Address)

Nashville (City) Tennessee (State) 37205 (Zip Code) 615-284-6849 (Area Code / Phone Number)

Barbara Houchi (Signature) January 10, 2014 (Date) bhouchin@sth.org (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

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COPY-
SUPPLEMENTAL-1

Saint Thomas Midtown Hospital

CN1401-001

Saint Thomas Health

January 30, 2014

Mr. Phillip Earhart
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Certificate of Need Application CN1401-001
Saint Thomas Midtown Hospital

Dear Mr. Earhart:

Thank you for your letter of January 23, 2014, requesting clarification of certain items contained in our Certificate of Need application for the renovation of surgical suites, patient care areas and support space for the realignment and consolidation of total joint replacement services at Saint Thomas Midtown Hospital. This information is provided in triplicate, including a signed affidavit.

1. **Section A., Applicant Profile, Item 9**

   What is Saint Thomas Midtown Hospital's (STMH) contract status with TennCare Select and BlueCare? In the previously filed Certificate of Need application (CN1307-028A), the applicant indicated in July 2013 contract negotiations with TennCare Select were in place with the anticipation of completing the process by the end of 2013.

   Response: Negotiations are currently still in process. While it was anticipated that negotiations would be complete by the end of 2013, the applicant's understanding from correspondence with Blue Cross is that it is at the "top of the list" once they have finished other priority meetings.

2. **Section B.I., Project Description**

   Please clarify if the applicant plans to redistribute patients currently cared for on the eighth floor to currently unstaffed beds on the fifth and sixth floors. If so, how many beds on the fifth and sixth floor will be impacted?

Response: In order to provide the necessary square footage for the new eighth floor Joint Replacement center, two existing inpatient units will be relocated to the fifth and sixth floors of the Central Building at Saint Thomas Midtown. The existing 30 Medical Beds located on the eighth floor of the Stringfield Building will be relocated to a currently unstaffed 34 bed inpatient unit on the fifth floor of the Central Building, allowing for the construction of the new Surgical Suite. In conjunction with this relocation, the 34 Surgical Bed inpatient unit currently located on the eighth floor of the Kidd Building will be relocated to a currently unstaffed 34 bed inpatient unit on the sixth floor of the Central Building. This second move will allow us to create a comprehensive center for joint replacement patients on a single floor that includes dedicated private rooms.

Please clarify if there will be a decrease in the number of ORs at West Hospital if this project is approved.

Response: If this project is approved, it is anticipated that surgery renovations approved in CN1110-037 (West Hospital) will be modified to eliminate the addition of four operating rooms that would have increased the complement of available ORs to historic levels at West. Combining this reduction with other OR renovations planned as part of the West project (renovation of 12 ORs to create 9 "right-sized ORs") and a recently completed project CN1103-010 (combining 2 ORs to create 1 cardiac hybrid room at West), the number of ORs at West and Midtown remain neutral.

What is the current total complement of operating and procedure rooms at STMH and what will that complement be after project completion? What is the breakdown of operating rooms and procedure rooms by floor?

Response: Please see breakdown in the charts below showing the total complement of existing operating rooms compared to the proposed complement of operating rooms and distribution by floor.

Saint Thomas Midtown Hospital – OR's by floor – Existing vs. Proposed

STMH – Existing Operating Room Distribution	
Floor	**Number of Operating Rooms**
4th Floor – Central Building	17 - Operating Rooms
7th Floor – Central Building	9 - Operating Rooms
8th Floor – Stringfield Building	0 - Operating Rooms

STMH – Proposed Operating/Procedure Room Distribution	
Floor	**Number of Operating Rooms**
4th Floor – Central Building	15 - Operating Rooms
7th Floor – Central Building	9 - Operating Rooms
8th Floor – Stringfield Building	10 - Operating Rooms

The applicant intends to redistribute patients cared for on the eighth floor to the fifth and sixth floors of the hospital. Please clarify what is currently occupying the fifth and sixth floors of Midtown Hospital.

Response: Please see response above. The current fifth floor of the Central building is an unstaffed 34 bed inpatient unit and the sixth floor of the Central Building is an unstaffed 34 bed inpatient unit.

Where are the current joint replacement operating rooms, PCU and pre-recovery areas in relation to the fifth and sixth floors of Mid-Town hospital?

Response: The current joint replacement rooms and post-anesthesia recovery area are located on the fourth floor of the Central building within Midtown Hospital. The currently unstaffed nursing units are located on the fifth and sixth floors of the Central building. Relocating these nursing units is imperative to the one-floor concept of the project. This will allow all joint replacement services to be provided on the eighth floor of Midtown Hospital. This will improve efficiency, streamline patient flow, and enhance the patient experience.

Please describe the proposed central sterile processing center that will be located in the basement and how it will impact the efficiency and effectiveness of supply flow. What is the age of the current central sterile processing center and its location?

Response: The proposed central sterile processing department will be a dedicated unit, servicing only the new joint replacement center. The department will be connected to the joint surgical suite through a dedicated service elevator. The current central sterile processing department is located on the second floor, and will remain unaffected by this proposed project. The existing department will continue to service Saint Thomas Midtown, including the remaining operating rooms on campus.

Please verify that PACU is an acronym for post-anesthesia care unit. If so, please describe the proposed PACU.

Response: Yes, PACU is an acronym for Post-Anesthesia Care Unit. The unit as currently designed will include 12 private bays (11 bays + 1 isolation room) and will meet all required design guidelines as listed within the 2010 FGI Guidelines for Design and Construction of Healthcare Facilities.

The applicant states the renovation costs is $142.58 psf. However, it appears the applicant used total project cost to determine renovation cost psf. Please calculate renovation cost by dividing the square feet of the project into the proposed renovation cost.

Response: The stated renovation cost of $142.58 psf is, in fact, correct. It is the weighted average of all of the renovation costs (i.e. the individual room square footages multiplied by their associated cost per square foot, divided by the total renovation square footage of 94,337 sq ft).

3. Section B.II.A., Project Description

The applicant states two existing ORs on the eighth floor of Mid-Town Hospital will be relocated and resized (increasing the size from 333 square feet to 585 square feet each). However, on the square footage exhibit it appears the two ORs are currently located on the 4th floor. Please clarify.

Response: This is a typo in the text. There are currently no operating rooms on the eighth floor of Midtown Hospital, instead, the square footage chart is correct. The ORs being relocated are numbers 9 and 10, currently located on the fourth floor of Midtown Hospital. Please see **Attachment A** for a replacement page 9.

Please clarify where the existing Mid-Town central sterile unit is located.

Response: The existing STMH central sterile department is located on the second floor of the Stringfield Building. This unit will remain untouched during this proposed project, and will continue to service the existing Surgical Suites within the fourth and seventh floors of the Central Building. This project is proposing a new/dedicated central sterile unit within the Basement level of the Stringfield Building.

Please clarify where 5 Central, 6 Central and 8 Kidd is located.

Response: Please see **Attachment B** for a detailed Plot Plan, detailing the location of buildings on the campus, including the Central building, and the Kidd building.

If applicable, please revise the renovation cost psf on page 12 and on the square footage chart.

Response: Not applicable. As described in question 2 above, the renovation cost stated on page 12 and the square footage chart ($142.58 psf) is correct.

There appears to be a calculation error in total GSF in the third column of the Square Footage Chart. If needed, please revise and resubmit.

Response: Please see **Attachment C** for a replacement page 11, Square Footage Chart, with the corrected calculation for the total existing gross square footage in the third column.

4. **Section B. III., Project Description (Plot Plan)**

Please submit a revised plot plan that identifies where the proposed project will be located on the STMH campus. The current plot plan is in color. Please clearly mark the proposed project structure visible when copied in black and white.

Response: Please see **Attachment B** for a detailed Plot Plan, detailing the location of buildings on the campus.

5. **Section C Item 1.a. (Service Specific Criteria-Construction, Renovation, etc.)**

Please indicate the last renovation of operating rooms dedicated to joint replacement.

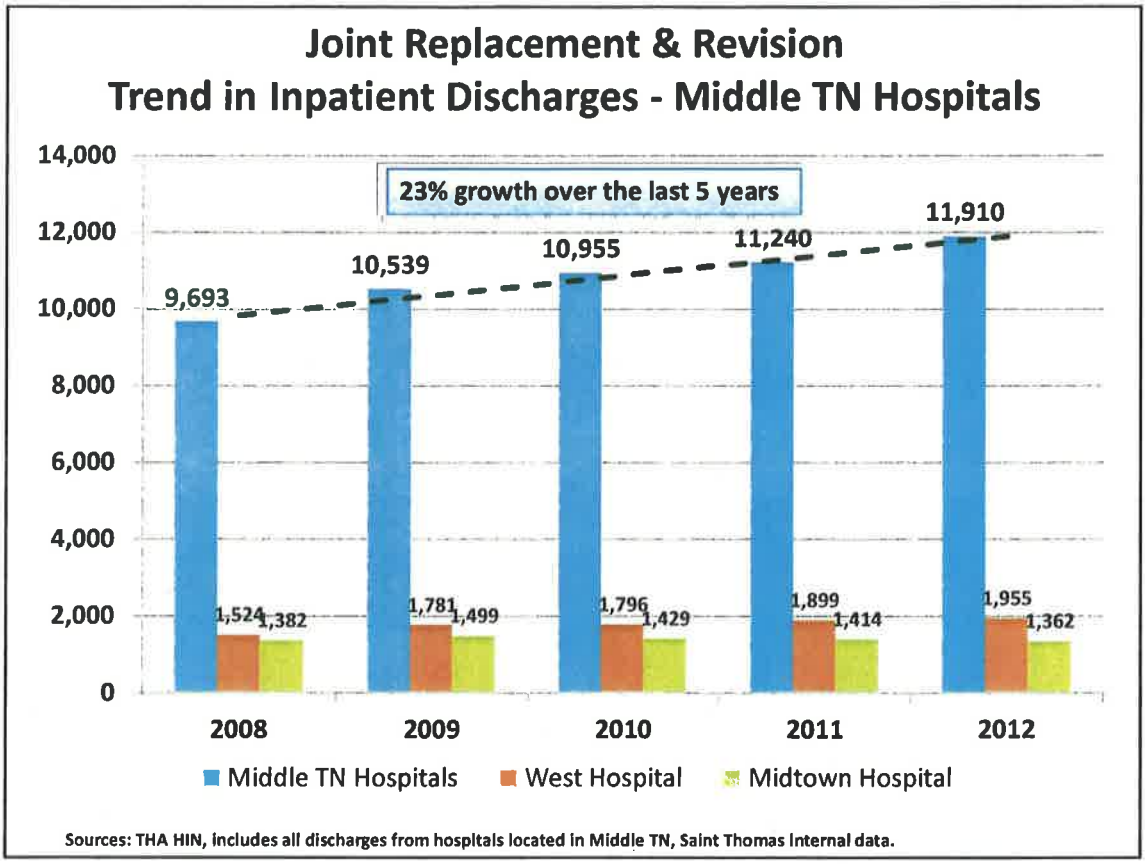
Response: In 2008, four ORs were consolidated into two ORs on the fourth floor of the Central building at Midtown Hospital. This changed the square footage of the two joint replacement ORs from approximately 400 square feet to approximately 600 square feet. The larger rooms are able to accommodate more modern equipment and technology. This renovation was only to two ORs, leaving several other ORs used for joint replacements at a less than ideal size. The proposed project seeks to accommodate the equipment and technology needed for joint replacement surgery.

What is the age of STMH.

Response: The Central building currently houses the joint replacement ORs on the fourth floor. It was built in 1955. The hospital's planning partners have advised against further major renovation to the Central building, specifically the ORs, due to its age and infrastructure. The Stringfield building is the hospital's newest structure. It was built in 1987. The proposed project will locate the joint replacement ORs to the eighth floor of the Stringfield building, a more ideal location that will complete the one-floor concept.

The chart of Joint replacement and Revision Trend in Patient Discharges-Middle Tennessee Hospitals is noted. Please add a bar in the graph for the years 2008-2012 for joint replacement surgeries conducted at West Hospital and STMH. This will compare the growth of joint replacement discharges in Middle Tennessee to the applicant's joint replacement surgery trend.

Response: Please see the updated chart below for a comparison of the growth in joint replacement discharges in Middle Tennessee with those at West and Midtown Hospitals. As displayed below, West and Midtown Hospital have seen an upward trend in joint replacement discharges over the five year period.



6. **Section C, Need, Item 4**

Is it correct that the median household income in the primary and secondary service area is expected to decline between 2014 and 2019? What are the factors five (5) counties will experience a decline in wages?

Response: Median household income data were obtained from Nielsen (f/k/a Claritas). Nielsen presents itself as a leading global information and measurement company, providing market research and data to, among others, Fortune 500 corporations. Nielsen demographic data are widely accepted in the healthcare industry.

Median household income data were verified. No discrepancies were found from the source reports to the CON application. In addition, trends in average household income follow the same patterns as median household income.

Please note that of the 13 geographic areas examined in Exhibit 7 (page 28) of the original CON application, 7 actually project an increase in median household income –

Davidson County, Maury County, Montgomery County, Rutherford County, Sumner County, Williamson County and Wilson County.

As a possible alternative, the Tennessee Department of Revenue website was consulted. No income projections were provided. However, a link to University of Tennessee Knoxville economic forecasts through 2022 did suggest slight income growth statewide. See http://cber.bus.utk.edu/erg/erg13app.pdf, PDF page 28.

Given these potentially conflicting findings, the applicant cannot venture a guess as to the factors affecting wages in the service area counties. That said, regardless of any projected trend in income, STMH's proposed project is not significantly dependent upon income projections.

The applicant states Nielson was contacted for clarification of their methodology and results, and is still pending. Please update.

Response: As stated in the original application, Nielsen was contacted for clarification of their methodology and results. A response is still pending.

7. **Section C, Need, Item 6**

Please also provide the following information:

Surgery ORs

Please complete the following two (2) charts for West Hospital and Midtown Hospital's OR complement.

Response: Please see **Attachment D** for the requested charts detailing West and Midtown Hospital.

8. **Section C, Economic Feasibility, Item 1**

For the Project Cost Chart, please list any moveable equipment over $50,000.

Response: The project will require four Washer Sterilizers at a cost of approximately $105,600 each, and one Cart Washer at a cost of $151,800.

9. Section C, Economic Feasibility, Item 2

Please identify on the applicant's financial statements specifically the source of the cash reserves that will be utilized for the proposed project.

Response: As submitted with the original application, the verification of funding letter from Craig Polkow, Chief Financial Officer, indicates that Saint Thomas Health has a centralized cash management approach for all of its hospitals. The June 2013 balance sheet (as submitted with the CFO's letter) indicates more than sufficient available funds in Other Long-Term Investments.

10. Section C, Economic Feasibility, Item 3

The applicant has stated that the cost per square foot is $142.58 including demolition. However, the applicant used overall project cost to calculate renovation cost psf. Please use actual renovation cost in calculating cost per psf.

Response: As detailed above, the renovation cost per square foot of $142.58 given on the square footage table is a weighted average, and is correct. Additionally, It is noted on both the original page 11, and replacement page 11 (**Attachment C**) that the reported costs do not include demolition or construction contingency.

11. Section C., Economic Feasibility, Item 4 (Historical and Projected Data Charts)

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised Historical and Projected Data Charts provided as an attachment. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

Response: Please refer to the more detailed Historical and Projected Data Charts provided in **Attachment E**. This project does not involve management fees, either to affiliates or non-affiliates.

Please clarify why bad debt increase from $9,962,000 in 2012 to $21,308,000 in 2013 on the Historical data Chart. In addition, please clarify why charity care decreased from $53,683,000 to $36,117,000 during the same time period.

Response: Changes related to bad debt and charity care amounts are multi-faceted:

- In the last couple of years, Saint Thomas Health has made process changes around financial assistance and the timing of when accounts are classified as indigent/charity. These changes include revising the timing of when an account is classified as charity versus self-pay based on completion of a charity application, as well as implementing an on-line charity care scoring tool which allows registrars to run a real-time charity assessment. While these changes have simplified the charity approval process, they may have resulted in inconsistent timing of the classification of accounts as reflected on the financial statements particularly as the applicant has fine-tuned the process.

- There has been a shift in the market to increased patient responsibilities or balance owed after insurance (higher deductibles in health plans) and thus in increased bad debt.

- The hospital's Finance department has made other process changes with the billing system to identify accounts that were not always being properly allocated to bad debt in a timely manner due to system logic.

- Overall, the applicant has not made any changes to the criteria or application of the charity care policy and, and instead point to the factors discussed above as contributing to the changes in charity care and bad debt amounts from 2012 to 2013.

The shift in West Hospital's joint replacement surgeries from 2,792 in 2015 to 600 in 2016 is noted. What is the financial impact of this shift to West Hospital? Please submit a Projected Data Chart for West Hospital.

Response: As part of the applicant's shift to a value-based model, Saint Thomas Health has cast a vision that the Midtown and West Hospitals be viewed seamlessly as one campus, taking advantage of the strengths of the individual facilities while merging operations to reduce costs. The applicant understands that there will be a financial impact of shifting joint replacement surgeries from West Hospital to Midtown Hospital,

but knows that this shift has other implications beyond this project. Upon approval of this proposed project at Midtown Hospital, Saint Thomas Health intends to undergo a thorough detailed evaluation of the master plan for West Hospital and expects there to be potential project scope changes related to the major renovation and expansion project currently underway on the West campus. A modification to that approved certificate of need project that would include the financial impact of this project will be forthcoming if appropriate and necessary.

12. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

Is the Projected Data Chart for Mid-town Hospital or for the proposed project?

Response: The projected data chart submitted is for Midtown Hospital. It includes the impact of the project as well as the impact of expected market changes in the coming years.

13. Section C, Economic Feasibility, Item 5

Please clarify the source document in determining the average gross charge, average deduction from operating revenue, and average net charge.

Response: The source for this information is historical internal data which takes into consideration expected reimbursement changes.

Internal data was used to compile this projection. Historical financial trends within the health system as well as expected market changes were considered. There is typically a small gross charge increase annually for all services at Midtown Hospital in an effort to remain price competitive in the market. It should be noted that Midtown Hospital is one of the lowest cost providers in Middle Tennessee, and there are no intent for this to change. For net revenue changes, changes aligned with the Affordable Care Act, including Medicare sequestration, were considered. It remains clear that as healthcare shifts from volume-based care to value-based care, hospitals will get paid less for the services they provide. All of these factors were considered in this projection.

14. Section C, Economic Feasibility, Item 6

The applicant states Mid-town Hospital expects that contractual and other adjustments will increase, which will result in lower net revenue per case. Please explain this statement.

Response: The applicant expects that market forces in the next few years will negatively affect hospital reimbursements, thus decreasing total net revenues, and in turn, net revenues per case.

15. Section C, Economic Feasibility, Item 9

The applicant estimates the payor mix for the project based is on Midtown's overall revenue. Since the proposed project involves joint replacement, should there be more than a 37.9% Medicare payor mix?

Response: The combined joint replacement programs are currently experiencing a 39% Medicare payor mix which is essentially the same as the overall hospital's payor mix. The applicant does not expect the payor mix to change as a result of this project.

16. Section C, Economic Feasibility, Item 11.a

Please clarify why the total current liabilities exceed current assets in the consolidated balance sheet for Ascension Health alliance for the period ending June 30, 2013.

Response: Part of the advantage of being part of a large national system is the ability to consolidate funds for investment. Ascension Health minimizes cash for operations and maximizes investments with the ability to manage long-term investments and convert into cash as needed for operations.

Please discuss the major construction currently taking place at West Hospital.

Response: The major facility renovation and construction project at West Hospital is a phased project, to be implemented over five years in order to minimize disruption to patient care. Phase 1 of the project – which includes renovation of the hospital's critical care beds on the second floor (44 critical care beds on units 2A/2B/2C) – is complete. The next phase includes renovations and updates to the surgery area. Related construction documents have been reviewed and approved by the Department of Health with construction scheduled to begin February 1, 2014, for the renovation of twelve undersized operating rooms to create nine larger multi-purpose operating rooms.

A signed affidavit is provided in **Attachment F**.

Saint Thomas Health

SUPPLEMENTAL- # 1
January 29, 2014
2:56pm

On behalf of Saint Thomas Midtown Hospital and the entire Saint Thomas Health system, thank you for the opportunity to present our case for the upgrade of highly complex orthopedic joint replacement and fracture surgery services.

Respectfully,

Barbara Houchin

Barbara Houchin
Executive Director, Planning

Attachments

SUPPLEMENTAL- # 1
January 29, 2014
2:56pm

Attachment A

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

RESPONSE: This project involves renovation to build a center of excellence for total joint replacement services that includes a ten room operating suite for consolidation of joint replacement programs for Saint Thomas Health's two Nashville hospitals – West and Midtown. This project also capitalizes on the strengths of two award-winning total joint replacement programs.

Midtown Hospital has 26 operating rooms, including two orthopedic operating rooms used primarily for joint replacement surgery and fracture surgery. These operating rooms will be relocated to a new total joint replacement surgery suite on the eighth floor.[1]

The operating room suite at Midtown Hospital will be a replacement of existing operating rooms at Midtown Hospital and West Hospital and will not result in an increase in the current number of operating rooms at both Midtown Hospital and West Hospital.

To stage the project, it will be necessary to:

- Renovate two existing nursing floors of the hospital, both located on the eighth floor but in interconnected towers, to create 62 private inpatient beds dedicated to total joint replacement services. Midtown Hospital will redistribute patients currently cared for on these nursing floors to the fifth and sixth floors of the hospital and, therefore, the hospital's licensed bed capacity will not change.
- Create a PACU with 12 private bays and a Prep/Recovery area with 20 private bays on the eighth floor, dedicated to total joint replacement surgery services.
- Resize and relocate two existing ORs on the fourth floor of Midtown Hospital (increasing the size from 333 square feet each to 585 square feet each).
- Create a new central sterile processing center in the basement and connected to the eighth floor via a dedicated elevator bank.

The ten operating rooms will measure approximately 585 square feet each. The PACU will measure approximately 90 square feet per bed and the Prep/Recovery will measure approximately 120 square feet per bed.

[1] These two operating rooms will be used for storage within the sterile OR environment until such time that a more appropriate use for the space is determined.

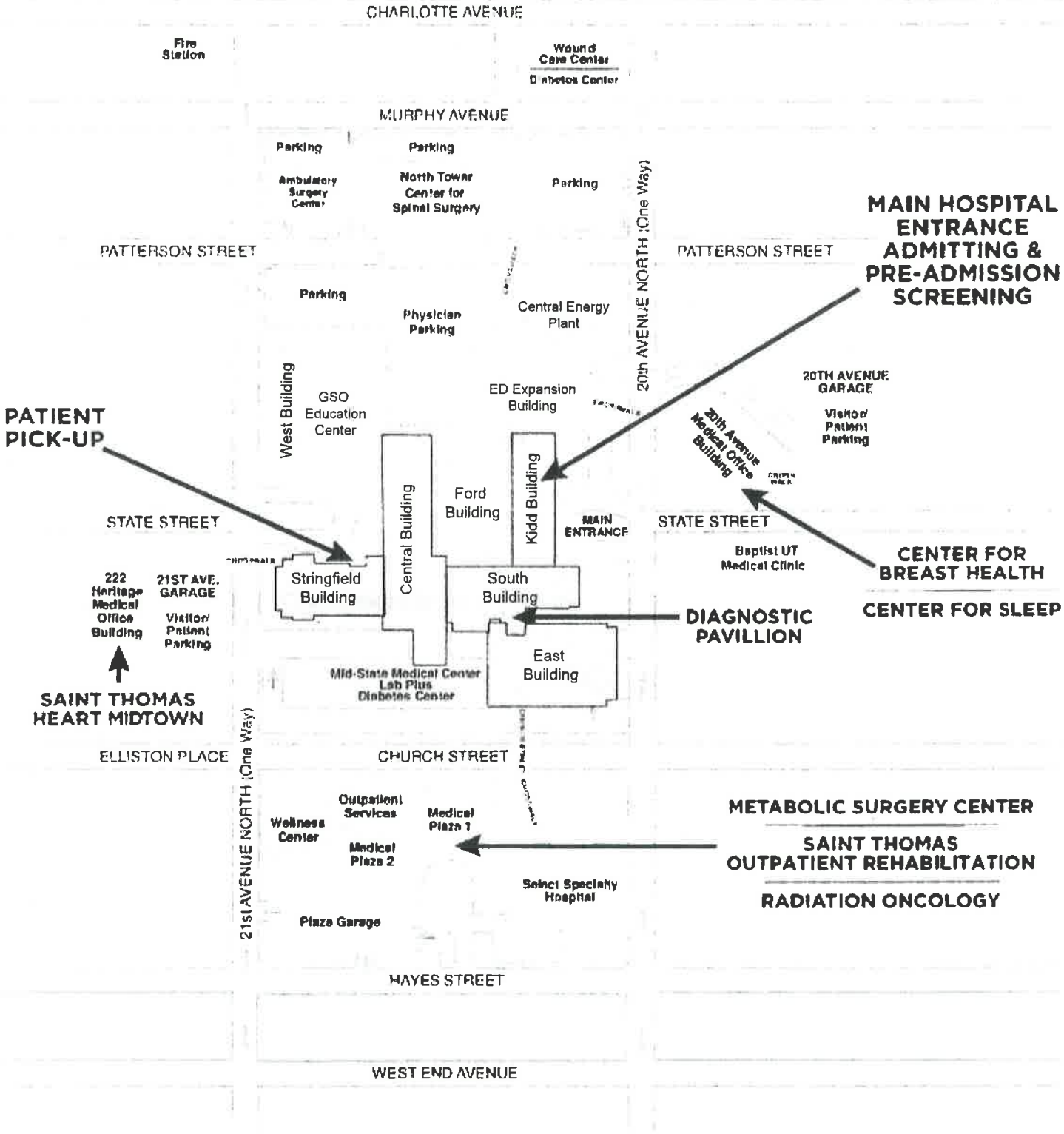
Attachment B

Saint Thomas
MIDTOWN HOSPITAL

SUPPLEMENTAL- # 1
January 29, 2014
2:56pm

2000 Church St, Nashville, TN 37236
615.284.5555 | www.STMidtown.com

Saint Thomas Physician Associates at Midtown Family Practice
Patient Information: 615.284.5288



Free parking is available for patients and visitors in the 21st Avenue, 20th Avenue and Plaza parking garages. The Mid-State Garage offers free parking for Mid-State Medical Center, obstetrics, joint replacement center and cardiovascular lab patients only (no visitor parking). Free valet parking is available Monday to Friday from 6 a.m. to 4 p.m. at the 20th Avenue Main Entrance to the hospital.

Attachment C

Square Footage Exhibit

Unit/Dept.	Existing Location	Existing Sq. Ft.	Temporary Location	Proposed Final Location	Proposed Final Sq. Footage			Proposed Final Cost/Sq. Ft.		
					Renovated	New	Total	Renovated	New	Total
OR #1 - Class C, Major	4th Floor	333	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #2 - Class C, Major	4th Floor	333	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #3 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #4 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #5 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #6 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #7 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #8 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #9 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #10 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR Support	N/A	N/A	N/A	8th Floor	10,900	N/A	10,900	$200	N/A	$200
PACU/Support	N/A	N/A	N/A	8th Floor	4,162	N/A	4,162	$290	N/A	$290
Prep/Recovery Support	N/A	N/A	N/A	8th Floor	10,200	N/A	10,200	$275	N/A	$275
Central Sterile	N/A	N/A	N/A	Basement Level	3,750	N/A	3,750	$300	N/A	$300
5 Central Patient Unit	5 Central	16,750	N/A	5 Central	16,750	N/A	16,750	$30	N/A	$30
6 Central Patient Unit	6 Central	16,750	N/A	6 Central	16,750	N/A	16,750	$30	N/A	$30
8 Kidd Patient Unit	8 Kidd	18,750	N/A	8 Kidd	18,750	N/A	18,750	$53	N/A	$53
Registration/PAT/Education	N/A	N/A	N/A	1st Floor - North Tower	5,625	N/A	5,625	$150	N/A	$150
Unit/Dept GSF Sub-Total		54,516	N/A		92,737	N/A	92,737	$140.73	N/A	$140.73
Mechanical/Electrical GSF	Mechanical Penthouse		N/A							
Circulation/Structure GSF	Central Lobby - Corridor Upgrades	1,600	N/A	Central Lobby	1,600		1,600	$250	N/A	$250
Total GSF		56,116	N/A		94,337		94,337	$142.58	N/A	$142.58

Note: Does not include demolition and construction contingency.

Attachment D

SUPPLEMENTAL- # 1
January 29, 2014
2:56pm

West Hospital

Operating Room		**Current** Specialty Usage *(Single /Mixed (Please identify specialties)	**Current** Operating Room/ Size in Square Feet	**Current** Building	**Current** Floor		**Proposed** Specialty Usage *(Single /Mixed (Please identify specialties)	**Proposed** Operating Room/ **Size in Square Feet**	**Proposed** Building	**Proposed** Floor
#1	C1	Cardiac & Thoracic	652	N/A	2		Cardiac & Thoracic	652	N/A	2
#2	C2	Cardiac & Thoracic	637	N/A	2		Cardiac & Thoracic	637	N/A	2
#3	C3	Cardiac & Thoracic	640	N/A	2		Cardiac & Thoracic	640	N/A	2
#4	C5	Cardiac & Thoracic	697	N/A	2		Cardiac & Thoracic	697	N/A	2
#5	C6	Cardiac & Thoracic	666	N/A	2		Cardiac & Thoracic	666	N/A	2
#6	C7	Cardiac/Total Joint Replacement/Urology	701	N/A	2		Cardiac/Urology	701	N/A	2
#7	C8	Neurosurgery	1025	N/A	2		Neurosurgery	1025	N/A	2
#8	C9	Vascular	1010	N/A	2		Vascular	1010	N/A	2
#9	OR10	Total Joint Replacement/Orthopedics	525	N/A	2		General-All specialties	525	N/A	2
#10	OR11	Total Joint Replacement/Orthopedics & Neurosurgery	525	N/A	2		General-All specialties	525	N/A	2
#11	OR12	Total Joint Replacement/Orthopedics & Neurosurgery	525	N/A	2		General-All specialties	525	N/A	2
#12	OR13	Opthalmology	444	N/A	2		General-All specialties	575	N/A	2
#13	OR14	Gynecology	444	N/A	2		General-All specialties	575	N/A	2
#14	OR15	General-All specialties	444	N/A	2		General-All specialties	575	N/A	2
#15	OR16	General-All specialties	444	N/A	2		General-All specialties	575	N/A	2
#16	OR17	General-All specialties	444	N/A	2		General-All specialties	575	N/A	2
#17	OR18	General-All specialties	444	N/A	2		General-All specialties	575	N/A	2
#18	OR19	Vascular & general	444	N/A	2		General-All specialties	575	N/A	2
#19	OR20	Vascular & general	444	N/A	2		General-All specialties	575	N/A	2
#20	OR21	General-All specialties	444	N/A	2		General-All specialties	575	N/A	2
#21	OR22	General-All specialties	444	N/A	2		N/A	O.R. Eliminated - Relocated to STM	N/A	2
#22	OR23	General-All specialties	444	N/A	2		N/A	O.R. Eliminated - Relocated to STM	N/A	2
#23	OR24	Total Joint Replacement/Orthopedics & other specialties	444	N/A	2		N/A	O.R. Eliminated - Relocated to STM	N/A	2
#24	OR25	Total Joint Replacement/Orthopedics	488	N/A	2		General/Orthopedics	488	N/A	2
#25	OR26	Total Joint Replacement/Orthopedics	488	N/A	2		General/Orthopedics	488	N/A	2
#26	OR27	Total Joint Replacement/Orthopedics	658	N/A	2		General/Orthopedics	658	N/A	2
#27	OR28	Urology	371	N/A	2		Urology	371	N/A	2
#28	OR29	Total Joint Replacement/Orthopedics	658	N/A	2		General/Orthopedics	658	N/A	2

Note: Four proposed ORs (as approved in CN1110-037) as a part of the West project will be eliminated with the approval of this project. Another OR has already been eliminated through the project that combined two ORs to create one cardiac hybrid OR (CN1103-010)

SUPPLEMENTAL- # 1
January 29, 2014
2:56pm

Midtown Hospital

Operating Room	**Current** Specialty Usage *(Single /Mixed (Please identify specialties)	**Current** Operating Room/ Size in Square Feet	**Current** Building	**Current** Floor		**Proposed** Specialty Usage *(Single /Mixed (Please identify specialties)	**Proposed** Operating Room/ **Size** in Square Feet	**Proposed** Building	**Proposed** Floor
#1	General/Gynecology	472	Central	7		General/Gynecology	472	Central	7
#2	General/Gynecology	472	Central	7		General/Gynecology	472	Central	7
#3	General/Gynecology	424	Central	7		General/Gynecology	424	Central	7
#4	General/Gynecology	554	Central	7		General/Gynecology	554	Central	7
#5	Gynecology	458	Central	7		Gynecology	458	Central	7
#6	General/Gynecology	332	Central	7		General/Gynecology	332	Central	7
#7	General/Gynecology	332	Central	7		General/Gynecology	332	Central	7
#8	Plastics/General	332	Central	7		Plastics/General	332	Central	7
#9	Orthopedics (non-joint)/general	421	Central	7		Orthopedics (non-joint)/general	421	Central	7
#10	Urology/Cysto (Procedure Room)	322	Central	4		Urology/Cysto (Procedure Room)	322	Central	4
#11	Urology/Cysto (Procedure Room)	322	Central	4		Urology/Cysto (Procedure Room)	322	Central	4
#12	Total Joint Replacement/Orthopedics	600	Central	4		General-all specialites	600	Central	4
#13	Total Joint Replacement/Orthopedics	600	Central	4		General-all specialites	600	Central	4
#14	General-all specialites	449	Central	4		General-all specialites	449	Central	4
#15	General-all specialites	44	Central	4		General-all specialites	44	Central	4
#16	Neurosurgery/General	606	Central	4		Neurosurgery/General	606	Central	4
#17	Orthopedics (non-joint)/general	447	Central	4		Orthopedics (non-joint)/general	447	Central	4
#18	General-all specialites	393	Central	4		Total Joint Replacement	585	Stringfield	8
#19	General-all specialites	393	Central	4		Total Joint Replacement	585	Stringfield	8
#20	Total Joint Replacement/Orthopedics	393	Central	4		General-all specialites	393	Central	4
#21	Total Joint Replacement/Orthopedics	601	Central	4		General-all specialites	601	Central	4
#22	Neurosurgery & Orthopedics	556	Central	4		Neurosurgery & Orthopedics	556	Central	4
#23	Vascular surgery	393	Central	4		Vascular surgery	393	Central	4
#24	General-all specialites	393	Central	4		General-all specialites	393	Central	4
#25	Cardiac	612	Central	4		Cardiac	612	Central	4
#26	Cardiac	597	Central	4		Cardiac	597	Central	4
#27						Total Joint Replacement	585	Stringfield	8
#28						Total Joint Replacement	585	Stringfield	8
#29						Total Joint Replacement	585	Stringfield	8
#30						Total Joint Replacement	585	Stringfield	8
#31						Total Joint Replacement	585	Stringfield	8
#32						Total Joint Replacement	585	Stringfield	8
#33						Total Joint Replacement	585	Stringfield	8
#34						Total Joint Replacement	585	Stringfield	8

Attachment E

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July. (Numbers reported in thousands, entire hospital)

		Year 2011	Year 2012	Year 2013
A.	Utilization Data (Patient Days)	113,135	112,163	108,732
B.	Revenue from Services to Patients			
1.	Inpatient Services	$690,544	$780,339	$862,034
2.	Outpatient Services	371,468	408,992	399,432
3.	Emergency Services	64,527	71,046	69,385
4.	Other Operating Revenue (Specify) - Misc.	15,775	29,405	27,821
	Gross Operating Revenue	$1,142,315	$1,289,782	$1,358,672
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$715,893	$806,267	$883,666
2.	Provision for Charity Care	24,972	53,683	36,117
3.	Provisions for Bad Debt	14,368	9,962	21,308
	Total Deductions	$755,234	$869,913	$941,090
NET OPERATING REVENUE		$387,081	$419,869	$417,582
D.	Operating Expenses			
1.	Salaries and Wages	$135,028	$133,380	$127,496
2.	Physician's Salaries and Wages	0	0	0
3.	Supplies	68,938	74,598	77,106
4.	Taxes	0	0	0
5.	Depreciation	17,371	16,425	16,627
6.	Rent	0	0	0

7.	Interest, other than Capital	9,899	9,195	8,524
8.	Management Fees:			
	a. Fees to Affiliates	0	0	0
	b. Fees to Non-Affiliates	0	0	0
9.	Other Expenses (See details below)	135,304	152,984	150,771
	Total Operating Expenses	$366,539	$386,582	$380,524
E.	Other Revenue (Expenses) - Net (Specify)	$285	$0	$0
NET OPERATING INCOME (LOSS)		$20,827	$33,286	$37,058
F.	Capital Expenditures			
1.	Retirement of Principal			
2.	Interest			
	Total Capital Expenditures	$0	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$20,827	$33,286	$37,058

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	**Year 2011**	**Year 2012**	**Year 2013**
1. Purchased Services	$30,868	$34,902	$34,181
2. Professional Fees	9,689	10,955	9,588
3. Miscellaneous	94,747	107,127	107,002
4.			
5.			
6.			
7.			
Total Other Expenses	**$135,304**	**$152,984**	**$150,771**

PROJECTED DATA CHART

Give us information for the two (2) years following the completion of this proposal. The fiscal year begins in July. (Numbers reported in thousands, entire hospital)

		Year 2016	Year 2017
A.	Utilization Data (Patient Days)	111,021	111,171
B.	Revenue from Services to Patients		
1.	Inpatient Services	$1,099,971	$1,108,971
2.	Outpatient Services	449,483	447,448
3.	Emergency Services	78,079	82,937
4.	Other Operating Revenue (Specify)	24,408	24,089
	Gross Operating Revenue	$1,651,941	$1,663,445
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$1,106,020	$1,109,629
2.	Provision for Charity Care	38,611	41,291
3.	Provisions for Bad Debt	28,339	30,306
	Total Deductions	$1,172,970	$1,181,226
NET OPERATING REVENUE		$478,971	$482,219
D.	Operating Expenses		
1.	Salaries and Wages	$144,807	$146,255
2.	Physician's Salaries and Wages		
3.	Supplies	91,165	91,594
4.	Taxes		
5.	Depreciation	19,336	19,916
6.	Rent		

7.	Interest, other than Capital	10,207	10,411
8.	Management Fees:		
	a. Fees to Affiliates	0	0
	b. Fees to Non-Affiliates	0	0
9.	Other Expenses (See details below)	165,119	165,169
	Total Operating Expenses	$430,634	$433,345
E.	Other Revenue (Expenses) – Net (Specify)	$0	$0
NET OPERATING INCOME (LOSS)		$48,337	$48,874
F.	Capital Expenditures		
1.	Retirement of Principal		
2.	Interest		
	Total Capital Expenditures	$0	$0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$48,337	$48,874

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	**Year 2016**	**Year 2017**
1. Purchased Services	$34,840	$35,181
2. Professional Fees	$10,237	$10,075
3. Miscellaneous	$120,042	$119,913
4.		
5.		
6.		
7.		
Total Other Expenses	**$165,119**	**$165,169**

SUPPLEMENTAL- # 1
January 29, 2014
2:56pm

Attachment F

SUPPLEMENTAL- # 1
January 29, 2014
2:56pm

JAN 29 '14 PM 2:51

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Saint Thomas Midtown Hospital

I, BARBARA HOUCHIN, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Barbara Houchin / Executive Director
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 29th day of January, 2014, witness my hand at office in the County of Davidson, State of Tennessee.

Diane Franklin
NOTARY PUBLIC

My commission expires January 9, 2018.

HF-0043

Revised 7/02

DIANE FRANKLIN
NOTARY PUBLIC AT LARGE
DAVIDSON TENN.

ORIGINAL-SUPPLEMENTAL-2

Saint Thomas Midtown Hospital

CN1401-001

Saint Thomas Health

SUPPLEMENTAL- #1
January 31, 2014
12:25pm

JAN 31 '14 P 2:28

January 31, 2014

Mr. Phillip Earhart
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: Certificate of Need Application CN1401-001
Saint Thomas Midtown Hospital

Dear Mr. Earhart:

Thank you for your letter of January 30, 2014, requesting clarification of certain items contained in our Certificate of Need application for the renovation of surgical suites, patient care areas and support space for the realignment and consolidation of total joint replacement services at Saint Thomas Midtown Hospital. This information is provided in triplicate, including a signed affidavit.

1. **Section B.I., Project Description**

   The applicant states the renovation costs is $142.58 psf. However, it appears the applicant used total project cost to determine renovation cost psf. Please calculate renovation cost by dividing the square feet of the project into the proposed renovation cost. This method of calculation is consistent with other new and renovated hospital construction projects recently approved and statistically trended by HSDA.

   Response: The cost of $142.58 per square foot that was originally presented in the CON application is a weighted average of all of the renovation costs (i.e., the individual room square footages multiplied by their associated cost per square foot, divided by the total renovation square footage of 94,337 sq ft). This cost per square foot does not include demolition and construction contingency.

   However, to remain consistent with other recently approved new and renovated hospital construction projects, the applicant has divided Line 5 - "Construction Costs", on Page 35 of the CON application, $15,155,862, by the total project square footage of 94,337, which amounts to a cost of $160.66 per square foot. Please see **Attachment A**

for application replacement page 8 which states this revised square footage cost calculation.

2. **Section B.II.A., Project Description**

   If applicable, please revise the renovation cost psf on page 12 and on the square footage chart.

   Response: Please see **Attachment B** for a replacement page 10, reflecting the updated cost per square foot calculation of $160.66. Also, please see **Attachment C** for an updated square footage chart.

3. **Section C, Economic Feasibility, Item 3**

   The applicant has stated that the cost per square foot is $142.58 including demolition. However, the applicant used overall project cost to calculate renovation cost psf. Please use actual renovation cost in calculating cost per psf.

   Response: Please see **Attachment D** for a replacement application page 36 indicating the revised square footage calculation of $160.66 per square foot, as discussed above. Please note that this revised renovation number remains comparable to other recently approved Tennessee CON projects.

A signed affidavit is provided in **Attachment E**.

On behalf of Saint Thomas Midtown Hospital and the entire Saint Thomas Health system, thank you for the opportunity to present our case for the upgrade of highly complex orthopedic joint replacement and fracture surgery services.

Respectfully,

Barbara Houchin

Barbara Houchin
Executive Director, Planning

Attachments

SUPPLEMENTAL- # 1
January 31, 2014
12:25pm

Attachment A

joint replacement, which are important and growing needs for an aging population. The current standard for orthopedic operating rooms is approximately 550 to 600 square feet. Midtown Hospital's orthopedic operating rooms measure approximately 333 square feet and do not provide adequate space. Similarly, four orthopedic operating rooms at West Hospital measure approximately 400 square feet and do not provide adequate space.

- Improve quality of care: Creating a center of excellence and consolidating the total joint replacement programs will improve the overall quality of total joint replacement care provided by both Midtown Hospital and West Hospital. The improvements in patient flow with total joint replacement surgery located on a single floor will enhance the patient experience. The "single floor experience" will allow Saint Thomas Health to improve staff collaboration and care coordination throughout the patient's entire episode of care from admissions to discharge. In addition, with larger operating rooms, total joint replacement surgeons will be able to perform more procedures that are complex by having the benefits of needed imaging equipment and larger operating tables in the operating rooms.

EXISTING RESOURCES: Currently, Midtown Hospital offers a continuum of surgical services, including total joint replacement surgery, and it will continue to do so. The proposed project will not result in Midtown Hospital terminating any services; it will only result in the consolidation and enhancement of its total joint replacement operating rooms and joint replacement program.

PROJECT COST: The total estimated cost of the proposed project is $25,832,609. Project costs include $15,155,862 for renovation (includes demolition and related construction costs) of 94,337 square feet ($160.66 per square foot). The cost per square foot is reasonable when compared to other Tennessee projects and is discussed later in the application.

FUNDING: Midtown Hospital will fund the project through centralized and unrestricted cash reserves held by Saint Thomas Health.

FINANCIAL FEASIBILITY: Midtown Hospital expects that construction and renovations will be completed and the project will be operational by September 2015. Projections for FY2016 and FY2017 indicate that the project is financially feasible. As explained below, this project is being proposed in order to improve access to care, economic efficiencies and quality of care without increasing charges to government and third-party payors.

STAFFING: This project will require only a modest increase in staff, approximately 9.7 new FTEs from the community. The majority of the increase at Midtown Hospital will include the relocation of approximately 35 FTEs now at West Hospital to Midtown Hospital. Midtown Hospital's salaries and wages are competitive with the market. Midtown Hospital has a history of successfully recruiting and retaining professional and administrative staff.

SUPPLEMENTAL- # 02
January 31, 2014
12:25pm

Attachment B

The total estimated cost of the proposed project is $25,832,609. Project costs include $15,155,862 for renovation (includes demolition and related construction costs) of 94,337 square feet ($160.66 per square foot). The cost per square foot is reasonable when compared to other Tennessee projects and is discussed later in the application.

No temporary relocation is required.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

RESPONSE: The proposed project does not affect the total bed complement at the hospital. The relocation of patients from the eighth floor to the fifth and sixth floors of the hospital will allow for the consolidation of 62 private inpatient beds dedicated to total joint replacement services on the eighth floor, contiguous to the proposed total joint replacement operating rooms, PACU and Prep/Recovery area.

SUPPLEMENTAL- # 10
January 31, 2014
12:25pm

Attachment C

Square Footage Exhibit

Unit/Dept.	Existing Location	Existing Sq. Ft.	Temporary Location	Proposed Final Location	Proposed Final Sq. Footage			Proposed Final Cost/Sq. Ft.		
					Renovated	New	Total	Renovated	New	Total
OR #1 - Class C, Major	4th Floor	333	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #2 - Class C, Major	4th Floor	333	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #3 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #4 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #5 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #6 - Class C, Major	Saint Thomas West	400	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #7 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #8 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #9 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR #10 - Class C, Major	Saint Thomas West	N/A	N/A	8th Floor	585	N/A	585	$495	N/A	$495
OR Support	N/A	N/A	N/A	8th Floor	10,900	N/A	10,900	$200	N/A	$200
PACU/Support	N/A	N/A	N/A	8th Floor	4,162	N/A	4,162	$290	N/A	$290
Prep/Recovery Support	N/A	N/A	N/A	8th Floor	10,200	N/A	10,200	$275	N/A	$275
Central Sterile	N/A	N/A	N/A	Basement Level	3,750	N/A	3,750	$300	N/A	$300
5 Central Patient Unit	5 Central	16,750	N/A	5 Central	16,750	N/A	16,750	$30	N/A	$30
6 Central Patient Unit	6 Central	16,750	N/A	6 Central	16,750	N/A	16,750	$30	N/A	$30
8 Kidd Patient Unit	8 Kidd	18,750	N/A	8 Kidd	18,750	N/A	18,750	$53	N/A	$53
Registration/PAT/Education	N/A	N/A	N/A	1st Floor - North Tower	5,625	N/A	5,625	$150	N/A	$150
Unit/Dept GSF Sub-Total		54,516	N/A		92,737	N/A	92,737	$140.73	N/A	$140.73
Mechanical/Electrical GSF	Mechanical Penthouse		N/A							
Circulation/Structure GSF	Central Lobby - Corridor Upgrades	1,600	N/A	Central Lobby	1,600		1,600	$250	N/A	$250
Total GSF		56,116	N/A		94,337		94,337	$160.66	N/A	$160.66

SUPPLEMENTAL- #16
January 31, 2014
12:25pm

Attachment D

2. Identify the funding sources for this project.
Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

___ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

___ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

___ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants--Notification of intent form for grant application or notice of grant award; or

__X__ E. Cash Reserves **(See Letter - Tab 13; See Cash line - Tab 15, Page 3)**

___ F. Other—Identify and document funding from all other sources.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

RESPONSE: At an average renovation cost of $160.66 per square foot for this project is comparable to other recently approved Tennessee CON projects. **Exhibit 11**, below, lists the average hospital construction cost per square foot for all CON-approved applications for years 2010 through 2012.

EXHIBIT 11
HOSPITAL CONSTRUCTION COST PER SQUARE FOOT
APPROVED PROJECTS, 2010 - 2012

	Renovated Construction	New Construction	Total Construction
1st Quartile	$99.12/sq ft	$234.64/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$259.66/sq ft	$235.00/sq ft
3rd Quartile	$249.00/sq ft	$307.80/sq ft	$274.63/sq ft

Source: Tennessee HSDA

SUPPLEMENTAL- # 12
January 31, 2014
12:25pm

Attachment E

SUPPLEMENTAL- # 12

January 31, 2014
12:25pm

JAN 31 '14 PM 12:28

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Davidson

NAME OF FACILITY: Saint Thomas Midtown Hospital

I, BARBARA HOUCHIN, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Barbara Houchin / Executive Director
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 31 day of January, 2014 witness my hand at office in the County of Davidson, State of Tennessee.

Diane Franklin
NOTARY PUBLIC

My commission expires 01/09, 2018.

HF-0043

Revised 7/02

DIANE FRANKLIN
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

Barbara Houchin
Executive Director, Planning
Saint Thomas Midtown Hospital f/k/a Baptist Hospital
2000 Church Street
Nashville, TN 37236

RE: Certificate of Need Application CN1401-001
Saint Thomas Midtown Hospital

Dear Ms. Houchin:

This will acknowledge our January 15, 2014 receipt of your application for a Certificate of Need for the renovation of surgical suites, patient care areas and support space for the realignment and consolidation of total joint replacement services at Saint Thomas Midtown Hospital, located at 2000 Church Street, Nashville (Davidson County), TN.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Thursday, January 30, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section A., Applicant Profile, Item 9**

   What is Saint Thomas Midtown Hospital's (STMH) contract status with TennCare Select and BlueCare? In the previously filed Certificate of Need application (CN1307-028A), the applicant indicated in July 2013 contract negotiations with TennCare Select were in place with the anticipation of completing the process by the end of 2013.

2. **Section B.I., Project Description**

   Please clarify if the applicant plans to redistribute patients currently cared for on the eighth floor to currently unstaffed beds on the fifth and sixth floors. If so, how many beds on the fifth and sixth floor will be impacted?

   Please clarify if there will be a decrease in the number of ORs at West Hospital if this project is approved.

What is the current total complement of operating and procedure rooms at STMH and what will that complement be after project completion? What is the breakdown of operating rooms and procedure rooms by floor?

The applicant intends to redistribute patients cared for on the 8th floor to the fifth and sixth floors of the hospital. Please clarify what is currently occupying the fifth and sixth floors of Midtown Hospital.

Where are the current joint replacement operating rooms, PCU and pre-recovery areas in relation to the fifth and sixth floors of Mid-Town hospital?

Please describe the proposed central sterile processing center that will be located in the basement and how it will impact the efficiency and effectiveness of supply flow. What is the age of the current central sterile processing center and its location?

Please verify that PACU is an acronym for post-anesthesia care unit. If so, please describe the proposed PACU.

The applicant states the renovation costs is $142.58 psf. However, it appears the applicant used total project cost to determine renovation cost psf. Please calculate renovation cost by dividing the square feet of the project into the proposed renovation cost.

3. **Section B.II.A., Project Description**

The applicant states two existing ORs on the eighth floor of Mid-Town Hospital will be relocated and resized (increasing the size from 333 square feet to 585 square feet each). However, on the square footage exhibit it appears the two ORs are currently located on the 4th floor. Please clarify.

Please clarify where the existing Mid-Town central sterile unit is located.

Please clarify where 5 Central, 6 Central and 8 Kidd is located.

If applicable, please revise the renovation cost psf on page 12 and on the square footage chart.

There appears to be a calculation error in total GSF in the third column of the Square Footage Chart. If needed, please revise and resubmit.

4. **Section B. III., Project Description (Plot Plan)**

Please submit a revised plot plan that identifies where the proposed project will be located on the STMH campus. The current plot plan is in color. Please clearly mark the proposed project structure visible when copied in black and white.

5. **Section C Item 1.a. (Service Specific Criteria-Construction, Renovation, etc.)**

Please indicate the last renovation of operating rooms dedicated to joint replacement.

What is the age of STMH.

The chart of Joint replacement and Revision Trend in Patient Discharges-Middle Tennessee Hospitals is noted. Please add a bar in the graph for the years 2008-2012 for joint replacement surgeries conducted at West Hospital and STMH. This will compare the growth of joint replacement discharges in Middle Tennessee to the applicant's joint replacement surgery trend.

6. **Section C, Need, Item 4**

Is it correct that the median household income in the primary and secondary service area is expected to decline between 2014 and 2019? What are the factors five (5) counties will experience a decline in wages?

The applicant states Nielson was contacted for clarification of their methodology and results, and is still pending. Please update.

7. **Section C, Need, Item 6**

Please also provide the following information:

Surgery ORs

Please complete the following two (2) charts for West Hospital and Midtown Hospital's OR complement.

West Hospital

Operating Room	**Current** Specialty Usage *(Single /Mixed (Please identify specialties)	**Current** Operating Room/ Size in Square Feet	**Current** Building	**Proposed** Floor		**Proposed** Specialty Usage *(Single /Mixed (Please identify specialties)	**Proposed** Operating Room/ **Size in Square Feet**	**Proposed** Building	**Proposed** Floor
#1									
#2									
#3									
#4									
#5									
#6									
#7									
#8									
#9									
#10									
#11									
#12									
#13									
#14									
#15									
#16									

#17									
#18									
#19									
#20									

Mid-Town Hospital

Operating Room	**Current** Specialty Usage *(Single /Mixed (Please identify specialties)	**Current** Operating Room/ Size in Square Feet	**Current** Building	**Proposed** Floor		**Proposed** Specialty Usage *(Single /Mixed (Please identify specialties)	**Proposed** Operating Room/ **Size** in Square Feet	**Proposed** Building	**Proposed** Floor
#1									
#2									
#3									
#4									
#5									
#6									
#7									
#8									
#9									
#10									
#11									
#12									
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#16									
#17									
#18									
#19									
#20									
#21									
#22									
#23									
#24									
#25									
#26/									
#27									
#28									

8. Section C, Economic Feasibility, Item 1

For the Project Cost Chart, please list any moveable equipment over $50,000.

9. Section C, Economic Feasibility, Item 2

Please identify on the applicant's financial statements specifically the source of the cash reserves that will be utilized for the proposed project.

10. Section C, Economic Feasibility, Item 3

The applicant has stated that the cost per square foot is $142.58 including demolition. However, the applicant used overall project cost to calculate renovation cost psf. Please use actual renovation cost in calculating cost per psf.

11. Section C., Economic Feasibility, Item 4 (Historical and Projected Data Charts)

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised Historical and Projected Data Charts provided as an attachment. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

Please clarify why bad debt increase from $9,962,000 in 2012 to $21,308,000 in 2013 on the Historical data Chart. In addition, please clarify why charity care decreased from $53,683,000 to $36,117,000 during the same time period.

The shift in West Hospital's joint replacement surgeries from 2,792 in 2015 to 600 in 2016 is noted. What is the financial impact of this shift to West Hospital? Please submit a Projected Data Chart for West Hospital.

12. Section C, Economic Feasibility, Item 4 (Projected Data Chart)

Is the Projected Data Chart for Mid-town Hospital or for the proposed project?

13. Section C, Economic Feasibility, Item 5

Please clarify the source document in determining the average gross charge, average deduction from operating revenue, and average net charge.

14. Section C, Economic Feasibility, Item 6

The applicant states Mid-town Hospital expects that contractual and other adjustments will increase, which will result in lower net revenue per case. Please explain this statement.

15. Section C, Economic Feasibility, Item 9

The applicant estimates the payor mix for the project based is on Midtown's overall revenue. Since the proposed project involves joint replacement, should there be more than a 37.9% Medicare payor mix?

16. Section C, Economic Feasibility, Item 11.a

Please clarify why the total current liabilities exceed current assets in the consolidated balance sheet for Acension Health alliance for the period ending June 30, 2013.

Please discuss the major construction currently taking place at West Hospital.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Friday, March 21, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ə 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency.

Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please contact this office.

Sincerely,

Phillip Earhart
HSD Examiner

Enclosure

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).

	Year____	Year___	*Year*____
A. Utilization Data (Specify unit of measure)	_____	_____	_____
B. Revenue from Services to Patients			
1. Inpatient Services	$_____	$_____	$_____
2. Outpatient Services	_____	_____	_____
3. Emergency Services	_____	_____	_____
4. Other Operating Revenue (Specify)_____	_____	_____	_____
Gross Operating Revenue	$_____	$_____	$_____
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$_____	$_____	$_____
2. Provision for Charity Care	_____	_____	_____
3. Provisions for Bad Debt	_____	_____	_____
Total Deductions	$_____	$_____	$_____
NET OPERATING REVENUE	$_____	$_____	$_____
D. Operating Expenses			
1. Salaries and Wages	$_____	$_____	$_____
2. Physician's Salaries and Wages	_____	_____	_____
3. Supplies	_____	_____	_____
4. Taxes	_____	_____	_____
5. Depreciation	_____	_____	_____
6. Rent	_____	_____	_____
7. Interest, other than Capital	_____	_____	_____
8. Management Fees:			
a. Fees to Affiliates	_____	_____	_____
b. Fees to Non-Affiliates	_____	_____	_____
9. Other Expenses – Specify on separate page 12	_____	_____	_____
Total Operating Expenses	$_____	$_____	$_____
E. Other Revenue (Expenses) – Net (Specify)_____	$_____	$_____	$_____
NET OPERATING INCOME (LOSS)	$_____	$_____	$_____
F. Capital Expenditures			
1. Retirement of Principal	$_____	$_____	$_____
2. Interest	_____	_____	_____
Total Capital Expenditures	$_____	$_____	$_____
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$_____	$_____	$_____

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in _____ (Month).

		Year_____	Year_____
A.	Utilization Data (Specify unit of measure)	_____	_____
B.	Revenue from Services to Patients		
	1. Inpatient Services	$_____	$_____
	2. Outpatient Services	_____	_____
	3. Emergency Services	_____	_____
	4. Other Operating Revenue (Specify)_____	_____	_____
	Gross Operating Revenue	$_____	$_____
C.	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	$_____	$_____
	2. Provision for Charity Care	_____	_____
	3. Provisions for Bad Debt	_____	_____
	Total Deductions	$_____	$_____
NET OPERATING REVENUE		$_____	$_____
D.	Operating Expenses		
	1. Salaries and Wages	$_____	$_____
	2. Physician's Salaries and Wages	_____	_____
	3. Supplies	_____	_____
	4. Taxes	_____	_____
	5. Depreciation	_____	_____
	6. Rent	_____	_____
	7. Interest, other than Capital	_____	_____
	8. Management Fees:		
	a. Fees to Affiliates	_____	_____
	b. Fees to Non-Affiliates	_____	_____
	9. Other Expenses – Specify on separate page 12	_____	_____
	Total Operating Expenses	$_____	$_____
E.	Other Revenue (Expenses) -- Net (Specify)_____	$_____	$_____
NET OPERATING INCOME (LOSS)		$_____	$_____
F.	Capital Expenditures		
	1. Retirement of Principal	$_____	$_____
	2. Interest	_____	_____
	Total Capital Expenditures	$_____	$_____

NET OPERATING INCOME (LOSS)	**$_____**	**$_____**
LESS CAPITAL EXPENDITURES		

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___	*Year*____
1.	$_____	$_____	*$*_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
Total Other Expenses	$_____	$_____	*$*_____

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___
1.	$_____	$_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
Total Other Expenses	$_____	$_____

State of Tennessee
Health Services and Development Agency
Frost Building, 3rd Floor, 161 Rosa L. Parks Boulevard, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

Barbara Houchin
Executive Director, Planning
Saint Thomas Midtown Hospital f/k/a Baptist Hospital
2000 Church Street
Nashville, TN 37236

RE: Certificate of Need Application CN1401-001
Saint Thomas Midtown Hospital

Dear Ms. Houchin:

This will acknowledge our January 29, 2014 receipt of your supplemental response for a Certificate of Need for the renovation of surgical suites, patient care areas and support space for the realignment and consolidation of total joint replacement services at Saint Thomas Midtown Hospital, located at 2000 Church Street, Nashville (Davidson County), TN.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Friday, January 31, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

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1. **Section B.I., Project Description**

   The applicant states the renovation costs is $142.58 psf. However, it appears the applicant used total project cost to determine renovation cost psf. Please calculate renovation cost by dividing the square feet of the project into the proposed renovation cost. This method of calculation is consistent with other new and renovated hospital construction projects recently approved and statistically trended by HSDA.

2. **Section B.II.A., Project Description**

   If applicable, please revise the renovation cost psf on page 12 and on the square footage chart.

3. **Section C, Economic Feasibility, Item 3**

The applicant has stated that the cost per square foot is $142.58 including demolition. However, the applicant used overall project cost to calculate renovation cost psf. Please use actual renovation cost in calculating cost per psf.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is Friday, March 21, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

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Should you have any questions or require additional information, please contact this office.

Sincerely,

Phillip Earhart
HSD Examiner

Enclosure